

THE MEDICAL NEWS.

A WEEKLY JOURNAL OF MEDICAL SCIENCE.

VOL. LX.

SATURDAY, MARCH 5, 1892.

No. 10.

ORIGINAL ARTICLES.

OBSCURE FORMS OF GOUT.¹

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SOME years ago a friend of mine, a physician, while travelling in Europe, was the subject of an obscure sense of ailing. He was not absolutely ill, he thought, but was not quite well, and had a feeling of depression for which he could not account. Being in London, he made up his mind to consult Sir William Jenner. After a visit, at which Sir William subjected him to a careful physical examination, he was surprised upon being told that his trouble was gout. His surprise finding some expression in his countenance, Sir William said to him: "You do not believe me, but you will find I am right. You Americans know little about gout, because you do not see much of it, and what you see you do not recognize." Within a few days my friend awoke one morning with a most obvious attack of gout in one of his feet; and his respect for gout and for Jenner's diagnostic ability was considerably increased.

This story is so closely in the line of some recent observations of my own that I have chosen it to introduce a brief presentation of them and the reflections to which they have given rise in my mind.

Gout is a disease that, in the last few centuries, has been studied with great thoroughness by the English, the French, and the Germans, and it is probable that the earlier American physicians, following the teachings of older and contemporary English writers, and dealing with patients of habits very similar to those of their English ancestors, were alert to detect its presence. But I have the impression that Sir William Jenner did not exaggerate much when he expressed so strongly the idea that in our day gout is not taken into account by American physicians as it ought to be, while an indication as to the degree of attention it has received from the American authors of medical works may be found in the fact that the Index Catalogue of the Surgeon-General's Library at Washington contains nearly twelve columns of titles of books on gout, and among them I find only three books—and these not imposing—by American writers.

Within the past few months three cases of gout—among others—have come under my care, which strikingly illustrate the importance of recognizing forms of gout that depart from the picture usually regarded as typical. These cases have been so instructive to me that I think it may be of service to describe them.

The first of the cases was that of a gentleman of means, but actively engaged in a business that required much thought and involved serious responsibilities. He is about fifty-five years old, of full habit, and "a good liver," but free from all forms of intemperance. Near the end of last winter his son brought him to my office in a condition that is hard to describe, but one that each of us has probably often seen. The man did not present any marked signs of disease, but he was pitifully unnerved and broken down. His appetite was poor, his sleep disturbed, his bowels somewhat irregular. He seemed so much to need mental rest that I suggested that he go away to Florida. I wished to examine his urine, but he slipped away to a health resort in North Carolina before I had an opportunity to do so. He came back in a few days feeling much better, and I did not hear from him for some time. Several months later, I was asked to see him by his regular family physician, and found that after a short spell of feeling out of sorts, he had fallen one day on the staircase of his house in what was called a "faint." On inquiry I found that in the "faint" the patient had continuously opened and closed one hand. In other words his attack was not one of syncope, but a convulsion. His regular attendant and I agreed that we must study his urine, and on doing so I found in it a large number of crystals of uric acid. As he was at that time about to go with his family to Europe, I warned him in regard to the dangers of the gouty diathesis, and advised him how to avoid them as far as possible. A few weeks later he wrote me from Paris: "You are a good prophet; I have just had a pronounced attack of gout in the foot." Since then he has returned to his home, and had several more attacks of equally typical character.

The second case was that of a lady living in the quiet of an admirable family. Nearly two years ago, she had an attack of "grip" when the epidemic was most severe in this country. After that she was never quite as well as she had been before. About six months ago she began to suffer with pains of a neuralgic character, which were especially severe in the thighs and in the lower part of the back, and which appeared also in the chest-wall and elsewhere. Some of these closely resembled the pains of sciatica. She was not under my care; but once or twice in the

¹ Read before the College of Physicians, March 2, 1892.

absence of her regular physician, I was called to see her; once when I gave her a subcutaneous injection of one-quarter of a grain of morphine, I was much impressed with the fact that this dose of morphine quieted her and kept her asleep or sleepy for fully thirty-six hours. Some time after this, while away from home, she suddenly developed symptoms of advanced disease of the kidneys, and was brought home, with waxy complexion, edema of the face and legs, oppressed breathing and a general appearance of the phenomena of contracted kidneys, and died in twenty-four hours. This patient's knuckles were knobbed, and I have no doubt, from a long acquaintance with her, from observations made on occasional visits, and from the manner of her death—for ten hours preceding which I had her under almost constant observation—that she died of contracted kidney due to gout.

A third case of gout that did not present the most conspicuous manifestations of the disease was that of a physician, about forty-five years old, a man of means and not in practice. Last June he sent for me, and when I came, he said: "I am afraid to see you; because I think that I have an aneurism of the aorta, and I fear you will confirm my opinion." He then described symptoms, some of which are found in cases of aneurism of the aorta, and submitted to a thorough physical examination. I found no evidence of aneurism whatever, and told him so, when he naturally asked me how I accounted for his symptoms. In preparing an answer to this query, I inquired pretty fully into his history and examined his urine. The former gave distinct points consistent with a theory of gout, and the urine showed an abundance of crystals of uric acid and oxalate of lime, some kidney epithelium, and no casts, albumin, or sugar.

I then told my friend that I believed his symptoms were due to gout, and advised a regimen in accordance with that theory, and the use of a natural mineral water which I have found advantageous in similar cases. In a few days he felt better; in a few weeks he felt well; and to-day he is apparently in perfect health. A year ago he was unable to enjoy anything; to-day he is full of spirit and enjoys everything. A year ago he could not walk a hundred yards on a slight ascent, without dyspnea and precordial distress; now he walks miles with ease and pleasure.

It would be a work of supererogation for me to dwell upon the symptoms and course of frank gout, for these are familiar to every practitioner of experience, especially in our older cities. In throwing off the British yoke the American colonists secured no independence from the diseases of their British progenitors; and the tendencies that our forefathers inherited, though they may have been kept in abeyance while the nation was passing through the arduous and heroic epochs of its early history, seem to be finding more pronounced expression, now that the number of persons living in comparative ease or actual luxury is increasing. As it was in

Greece and Rome, so it has been in England and on the continent of Europe, and so it is likely to be in America. Abernethy's advice to "live on a shilling a day, and earn it," indicates a road to health that is constantly being deserted by Americans, and as a result, the diseases of over-feeding and inadequate muscular exercise must become more conspicuous among us. For this reason gout is likely to secure more and more victims in this country, and consequently it is well that American practitioners should be prepared to recognize not only its striking forms, but also those that are irregular or obscure.

In his classical work on *Gout and Rheumatic Gout*, Garrod says that, while gout in its most marked and typical manifestations is exceedingly prevalent in England, "in its lurking and undeveloped forms it is probably still more so, and exercises a considerable influence over the character and progress of other disorders." From this, it is a natural step for him to emphasize the importance of properly distinguishing gout from other diseases, of recognizing it when it is present, and at the same time avoiding the error of attributing to gout what are really manifestations of other disorders. Everyone who becomes especially interested in a particular disease is in some danger of falling into such an error, and the more likely to do so as the idea of anomalous forms of that disease takes possession of his mind.

In determining the diagnosis of gout we must study the history of the case—the hereditary tendency of the patient, the existence of predisposing or exciting causes, and the symptoms. In retrocedent gout—that is, the development of visceral disorders or lesions upon the disappearance of gout from the joints—the case is simple, although Garrod aptly quotes a remark by Watson that "so-called *gout* in the stomach has sometimes turned out to be *pork* in the stomach." There is undoubtedly a form of dyspepsia in persons predisposed by heredity to gout that may justly be attributed to this disease; and this form of dyspepsia is sometimes relieved upon the appearance of gout in a joint, while treatment suitable to gout proves curative of it.

Gout of the heart is often associated with gouty dyspepsia; but Garrod speaks of cases in which palpitation, and irregularity of rhythm have been produced by the state of the blood. Dyce Duckworth, in his elaborate work on *Gout*, emphasizes the importance of what may be called minor symptoms of disturbed action of the heart, such as giddiness and dimness of vision, in gout. A case of my own has impressed me with a similar conviction. I am myself inclined to believe that certain forms of angina pectoris are dependent upon the gouty dyscrasia. I have seen three cases in which long-continued disturbance of the functional action of the heart

seemed to me to be altogether dependent upon gout, to which the patients were liable by heredity or by their habits, and of which they presented other manifestations. This is a subject that I think deserves very careful investigation, so that we may ascertain just how far we may look to the gouty habit to account for heart symptoms that are not otherwise easy of explanation.

The effect of gout in producing cough, dyspnea, and even asthma, is recognized by almost all authors, but there is danger, I think, of attributing such disorders unjustly to gout, with which they may be merely coincident. At the same time it is proper to recognize that, if not directly induced by gout, the conditions named may be exaggerated or made less amenable to ordinary methods of treatment by reason of the gouty dyscrasia. Examples of this tendency have certainly occurred in my practice.

The kidneys are probably the organs that are most likely to undergo serious alterations in consequence of unsuspected gout, and a recognition of this fact is of the utmost importance. Draper, in his admirable article on gout in Pepper's *System of Medicine*, speaks forcibly of the insidious character of gouty nephritis, and states that gout of the kidney is the most common cause of death in this disease. The observations of other writers on gout are in accord with this statement, and it can hardly be dwelt upon too strongly in studying the possibilities of gout. In one of the cases briefly described I believe that a careful study of the history of the patient, and a due consideration of the possibilities of gout, would have prevented a very erroneous prognosis on the part of one physician who treated her, and perhaps have led to a more appropriate line of treatment.

In this particular case a consultant of large experience was quoted to me as treating with apparent unconcern the state of the kidneys, because the quantity of albumin found in the urine was small!

Such a statement suggests either an error in the account of what was said, or a serious misapprehension of the significance of the presence of small quantities of albumin in the urine. On the other hand, it is possible that large quantities of albumin may be found in the urine during comparatively slight attacks of gout. Very recently I had under my care a young lady who was suffering with an attack of podagra, very well defined but of moderate severity, whose urine contained enough albumin to make, with underlying nitric acid, a coagulum one-third of an inch thick. This patient presented no other symptom of kidney disease—her urine was repeatedly and thoroughly examined—and she made a good recovery from her attack of gout.

Temporary glycosuria is another evidence of faulty nutrition or disordered excretion which is

found in some cases of gout. Dyce Duckworth points out the danger of mistaking this phenomenon for diabetes mellitus, and especially of communicating this erroneous belief to the patient or his friends.

The influence of gout upon the skin has been especially emphasized by certain French observers. Draper cites Bazin (*Affections génériques de la Peau*, Paris, 1862) as describing functional derangements of the skin dependent upon gout, such as excessive perspiration, seborrhea, alopecia, pruritus, urticaria, and erythema. Eczema is a well-recognized manifestation of the gouty diathesis, and Draper calls attention to the frequency of acne in persons predisposed by heredity to gout. Garrod, in 1881, stated that he regarded eczema as the special skin-lesion of gouty subjects. I have noticed a peculiar fetid, or rather a sour perspiration in a few persons belonging to gouty families, some of whom in time developed frank attacks of gout. As connected with the skin, it is interesting to note that Dyce Duckworth speaks of spontaneous loosening and falling out of the teeth as a manifestation of gout.

One of the most important manifestations of obscure gout is neuralgia. There is hardly a writer on gout who fails to call attention to this feature of the disease, and yet I believe it is by no means properly appreciated. The neuralgia of gout may affect any region that an ordinary neuralgia may invade, and may easily be misinterpreted. This is especially true of the sciatic region; so that what is only a manifestation of gout may be called sciatica. One feature of such cases that may be noted is the fact that the neuralgia of gout appears in various places at the same or at different times. The ham, the calves of the legs, the loin, the side of the chest, the arm, and the area of distribution of the fifth pair of nerves, may be the seat of severe and even agonizing pain; and this very shifting of location ought to warn the physician to carefully consider the possibility that gout is the cause of the phenomena.

Other manifestations of gout in the nervous system are vertigo, loss of consciousness, and even epileptiform convulsions. These are rarely of a very pronounced character, but Garrod mentions one case under his observation, and one of the cases I have described presented this group of symptoms. The relation of gout to this and other forms of cerebral disturbance is not yet clearly defined, and it would probably be useful for men of large experience to study their cases with especial reference to this relation. In my practice I have observed that in some subjects gout has a peculiarly depressing influence, so that they are easily disheartened, and lack vigor of will. Laycock has called attention to the influence of gout in producing hysteria, and many

authors connect it with hypochondriasis. Dyce Duckworth has been so impressed with the nervous features of gout that he defends the hypothesis that gout is a neurosis. He also speaks of the occurrence in gout of violent pains in the muscles—as, for example, cramps in the legs.

These remarks do not by any means cover all the manifestations of gout that may be misunderstood, but which, if duly considered, may lead to its diagnosis when what are universally recognized as its typical symptoms are absent; but it is hoped that they may serve to attract attention to, and perhaps also throw a little light on, a subject that is of some consequence in our study and treatment of disease.

As already stated, I have the impression that in this country gout often escapes diagnosis, and that it would be better for our patients if we were on the alert to detect its less familiar features. We do not want to deceive ourselves by a too ready disposition to find gout where it is not actually present; but, to keep in mind that gout may be the cause of a great variety of symptoms, and to know what some of these symptoms are, may at times make our diagnosis much more satisfactory and our treatment much more successful than they otherwise would be.

DIPHTHERIA TREATED BY THE EARLY LOCAL USE OF GERMICIDES.¹

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DIPHTHERIA is admitted to be a disease caused by a microscopic germ or bacillus commonly known as the Löffler bacillus, or more often called the Klebs-Löffler bacillus. The only point now in dispute is as to whether other poisonous microorganisms (saprophytes), as well as the Löffler bacillus, have the power to cause diphtheria.

The course and termination of a case of true diphtheria in man, is typically characteristic of the invasion of a living organism by a poisonous germ. There is first the period of incubation, sometimes marvellously short, in some cases extending over a period of a few days, or even hours; this is, of course, the period when the bacillus is germinating and preparing to do its deadly work. Then generally follow the initial chill and fever—temperature ranging from 100° to 103½°, but without the defervescence that follows the chill of malarial fever. Coincidentally with or immediately following the chill, will generally be found, on some part of the tonsils, uvula, or pharynx, the characteristic yellowish or grayish-white exudation that has so often struck terror to our hearts. Then follows the steadily

advancing growth of the false membrane, extending backward and downward upon the walls of the posterior part of the pharynx, even to the larynx and trachea, or upward and backward to the posterior nares. As the exudation increases, there arises the enlargement of the submaxillary glands, and septic fever produced by the absorption of the poisonous ptomaines generated by the bacilli and absorbed into the blood. If unchecked, these symptoms continue until death speedily comes, either from strangulation, or what is much more frequently the case, from true septic fever, closely analogous or identical with that produced by the absorption into the system of the putrid material found in dissection wounds, hospital gangrene, or pyemia.

The plan of treatment I propose is not the application of new and untried remedies. On the contrary, it is simply the application of our old and well-known methods of treatment, in consonance with the laws that hinder the growth and destroy the bacterial germs that are the cause of diphtheria.

What germicide, then, or agent having power to destroy bacterial life, can we most readily use? Corrosive sublimate is the one almost universally used, and is the one that I have employed. I use it in spray and in a stronger solution than usually employed, viz.: one grain, with five grains of tartaric acid, in a little over a fluidounce of distilled water, 1:500; this is liberally sprayed at least once an hour for the first twenty-four or forty-eight hours. When the exudation disappears, I dilute the bichloride solution to 1:1000 or even 1:2000. After I am called to a case of diphtheria, alternately with this I apply every hour to the fauces and tonsils, with a camel's-hair throat-brush, a solution of twenty grains of chloral hydrate in a fluidounce of glycerin. These applications are to be made continuously for a period of from twenty-four to forty-eight hours, according to the gravity of the case, until the exudation begins to soften and peel off; the applications are not then made so frequently. The use of this is twofold; in the first place the continued use of the glycerin, aided by the powerful antiseptic action of the chloral hydrate, softens the false membrane and leaves a clean surface on which the bichloride of mercury can act. At the same time I direct either that water be kept boiling in the room, to saturate the air with moisture, or that lime be slaked in the room.

As to medical treatment, I give in solution from two to four grains of quinine every three hours, until from sixteen to thirty-two grains have been given, the dose being proportioned according to age. Then I commence and give the tincture of the chloride of iron in large doses every three hours alternately with the quinine. This treatment, continued

¹ Read before Medical Society, Washington, D. C., December 2, 1891.

for from forty-eight to seventy-two hours, has in my hands met with almost universal success.

The objection may be made to this treatment, that it is very laborious to the person who is nursing the child, and this is true.

When called, I say frankly to the parents that, in my opinion, the life of the child will depend upon sacrificing every other consideration, and for two or three days upon continuous and exclusive devotion to the care of the child.

About two years ago, I attended a child six years of age, attacked with diphtheria in its most malignant form. Day after day I watched the false membrane encroaching more and more upon the back part of the throat and soft palate. Then came enormous swellings of the submaxillary and parotid glands, which turned a livid purplish color. With this a condition of true septic fever developed, from the absorption of the poisonous ptomaines generated by the bacilli. All treatment seemed unavailing, and when I left the house after the child's death, I felt so completely disheartened with the failure of my attempt to save the child's life that I felt almost like abandoning the practice of medicine forever. Studying over this case and many others of like character that I had met with during the past years of my practice, I began to feel certain that my want of success was due to a lack of energy during the early stages of the disease, and that a more active treatment directed to stamping out the disease when it was just beginning its ravages would be the proper course to pursue.

These are the principles that have guided me in the treatment of the cases that form the basis of this paper. The number of cases was only fifteen, yet the result has been so uniformly good (as they have all recovered) that I now go to a case of diphtheria with a confidence of a successful result that I had never felt before.

I need not go into the detail of the histories of the cases, but will only give such points as may be interesting. The first five cases occurred in one family over a year ago, and after a prolonged struggle they all recovered. The next two cases occurred in October of this year in one family; one child of nine years brought the disease from the country, where she had been staying during the summer. She came home on Saturday and I did not see her until the following Tuesday. Her attack was quite severe, involving the fauces and posterior nares. She had infected her sister before I saw her. Case No. 8, in another family, was interesting from the fact of a relapse occurring on the ninth day from imprudent exposure. The diphtheritic exudation returned on the fauces, after having completely disappeared for several days; in this case I applied a strong solution of nitrate of silver to the patch of diphtheritic exu-

dation membrane, with excellent results. Case No. 9 was a girl, aged thirteen years, with quite extensive patches of membrane covering fauces, uvula, and tonsils. The temperature was 102° on the first day, and falling in three days to $100\frac{1}{2}^{\circ}$ (in morning), with a gradual abatement of all the symptoms. Case No. 10 was a girl, aged fifteen years. There was complete recovery in three weeks. Cases No. 11, 12, 13, 14 and 15 all occurred in one family. The two boys were first attacked, one fifteen years of age and the other five; then the two girls, aged ten and twelve years, respectively. Then the mother was attacked; and finally the infant child, eight months old, took the disease. In the case of the infant, after the exudation had disappeared from the throat, the disease assumed the form of a bronchial catarrh, and the case seemed well-nigh hopeless. The energetic use of stimulants, hot mustard-poultices, and the internal administration of carbonate of ammonium and spirits of turpentine in large doses saved the child's life.

As to other local remedies, I have used solution peroxide of hydrogen largely. It is an admirable deodorizer and disinfectant, but I have not found it as good a local application in diphtheria as the bichloride solution. Listerine, diluted with from one to four parts of water, is also an excellent application, used as a spray or gargle, when the bichloride seems to irritate, and for a time may require to be stopped. In none of my cases has the bichloride solution caused any symptoms of mercurial poisoning. Should symptoms arise, of course its use should be temporarily stopped, continuing, however, the swabbing of the throat with the chloral and glycerin solution, and substituting the diluted solution of peroxide of hydrogen (one part to four parts of water), used with an atomizer, in place of the bichloride of mercury solution.

As regards prophylaxis or prevention of diphtheria, granting that diphtheria is due to a poisonous germ it would seem to be proper to use weak germicides in the case of all persons who have been exposed to the contagion of the disease, even though they may not by any external symptoms show that they are infected. I would earnestly recommend, therefore, that the bichloride of mercury solution 1:2000 or even 1:4000, be used either as a spray or gargle five or six times a day by all persons residing in the house in which a patient is sick with diphtheria.

If the attending physician objects to this, let him use in the same way the diluted solution of peroxide of hydrogen or the solution of chloral hydrate in glycerin, twenty grains to the ounce of glycerin—this is to be diluted with three parts of water when used as a spray; or Listerine, diluted with from one to four parts of water, may be employed.

A careful and thorough examination of the throats

and mouths of the members of the family residing in the house in which a case of diphtheria exists should be occasionally made by the attending physician, in order that the disease may be detected in its early and curable condition.

After a somewhat lengthy experience of the effects of alcohol, I must most earnestly protest against the use of alcoholic liquids, especially when given in large doses. Alcoholic liquids are most valuable and indispensable remedies, but they should be given in small doses and repeated at regular and stated intervals. I rarely give more than one or two teaspoonfuls of good whiskey or brandy, well diluted and sweetened, every three, four, or six hours, according to the age and condition of the child. Alcohol, when given in liberal doses, it should be remembered, is not a stimulant, but on the contrary is a powerful narcotic and depressant. The action of alcohol upon the heart is like the use of a spur to a jaded horse, and its continued use in too large quantities will increase instead of diminishing the irregularity and feebleness of the circulation. I have seen cases of heart-failure and death after diphtheria which I feel convinced were hastened in their progress, if not entirely caused, by the injudicious use of alcoholic stimulants in too large and frequently repeated doses.

During the convalescence from diphtheria, small doses of whiskey or brandy should be given three times a day, after meals, to obviate the tendency to heart-failure that is apt to occur, and that sometimes happens even after convalescence has been thoroughly established. It is, of course, to be understood that during the treatment of the cases referred to in this paper care was given to keep up the strength of the patients by the liberal use of liquid and easily digested food.

FRACTURE OF THE BASE OF THE SKULL.¹

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It has been a generally accepted belief that a fracture at the base of the skull is almost necessarily fatal. Still, there is quite a number of cases on record in which the diagnosis of fracture of the base was made and the patient recovered. Wagner even ventured to state that when a patient with fracture at the base survives without untoward symptoms, it is pretty sure that he will recover. He cites twenty-three cases, all of which recovered—that is to say, that did not die within forty-eight hours after the accident. This has induced many surgeons to doubt the correctness of diagnosis in many of these cases. But there has been a sufficient number

of autopsies of such cases made to antagonize and refute the doubt. As shown by a large number of cases, the most frequent seat of fracture of the base is in the middle fossa, and the majority were in a transverse direction through the pyramidal petrous portion of the temporal bone. These fractures also have a tendency to branch forward along the side of either cavernous sinus into the sphenoidal fissure. This will explain certain symptoms of paralysis, as that of the third nerve, thus producing dilatation of the pupil and strabismus. Those fractures of the base are produced by a transmission of the impulse from the vertex or lateral portion of the calvarium. There is still another form of fracture, called fracture by *contre-coup*, the existence of which is doubted by some of the best authorities. These may be considered fractures by direct violence, in so far as the force is brought to bear directly on the point of impact, as when a man falls upon his feet in a rigid manner, and the base of the skull is broken through the foramen magnum, while the atlas may be dislocated into the cranial cavity; or, when falling on the face, the petrous portion is fractured, while perhaps one or the other head of the lower jaw is driven through the articular process, just as the head of a hammer may be driven into the handle by striking the handle against some solid object. These are the severest forms of fracture, and, of necessity, fatal. The fractures by blows from above, anteriorly, posteriorly or from either side, are as a rule mere fissures, and not comminuted fractures.

The immediate danger from a fracture at the base is that of injury to the brain-substance proper, its coverings, the bloodvessels, both cerebral and meningeal. The carotid artery is rarely, if ever, injured. If the injury to cerebral substance is slight, and no large bloodvessels are injured, the symptoms of concussion will rapidly disappear, and there will not be marked symptoms of compression, as the hemorrhage that would produce these is not sufficient to interfere with the functions of the brain.

After recovering from the immediate effects of the injury, the question of secondary inflammatory processes arises, provided there has been a dissolution of continuity in the vault of the pharynx, the roof of the nasal fossa, or the auditory meatus and tympanic cavity. However, with ordinary antiseptic precautions these dangers are reduced to a minimum. The patient, however, may succumb to an osteomyelitis, suppurative meningitis, abscess of the brain, or thrombosis. The healing of the bone takes place by the least possible amount of callus cementing the fissure.

The diagnosis of a fracture of the base is made from certain symptoms due to the communication of the fracture with one or more of the fossæ of the

¹ Read before the Milwaukee Medical Society, November 10, 1891.

skull. One or more of these symptoms will be present in all of the cases. If the fracture extends into the posterior or occipital fossa there will be ecchymosis into the mastoid region and in the neck; if in the anterior or middle fossa there will, as a rule, be ecchymosis of the orbits. These ecchymoses come on in a few days after the injury has taken place, and are quite diagnostic. These symptoms may be absent, however.

Hemorrhage may take place from the nose, the ears, and the mouth, and if blood has been swallowed there may be vomiting of blood, more or less modified by the gastric juice. The flow of blood from the ears does not necessarily indicate a fracture of the petrous portion, since a simple rupture of the tympanic membrane may give rise to a flow of blood from the external meatus. If, however, the flow continues for some time, one may be pretty sure that there is a fissure of the bone. Another symptom sometimes shows itself, and is of grave significance—the flowing of a limpid fluid from the external meatus, usually on one side. It is at first mixed with blood, but later assumes a straw-color appearance. It is generally agreed upon that this fluid is derived from the subarachnoid space, and is the cerebro-spinal or subarachnoid fluid. It sometimes appears in large quantities. Many of the cases in which this symptom appears are fatal, though a large number of them also do recover. If they recover, the flow ceases in six or seven days. This symptom may be present without any rupture of the tympanic membrane, as also may the flow of pure blood.

Besides injury to the brain-substance itself, certain nerves are very often partly or completely torn, or there may be neuritis with effusion, resulting in compression of the nerves, with paralysis of the muscles supplied. Those most commonly injured are the facial and acoustic, which are directly in the line of the most frequent seat of fracture, the third nerve or motor oculi, and the sixth or abducens—in fact, any nerve or group of nerves may be implicated.

I have already said that fractures at the base are not as fatal as was formerly supposed, though some doubt the correctness of diagnosis in those cases that recover rapidly. It is a fact that though they do recover, there are defects, sometimes imbecility and other cerebral symptoms, as epilepsy, etc., or defects of innervation, which may be permanent. Very often, however, the nerves recover their functions almost or quite completely. As to treatment, there is only one indication that can be fulfilled, and that is antisepsis. Of course, absolute rest is necessary. If there has been bleeding from the nose this cavity must be frequently syringed with a non-irritating antiseptic solution. Both ears and nose may be syringed with a concentrated boric-acid solution, and boric-acid powder

should be blown into the auditory canals. Mild diet, and perhaps an ice-bag to the head, are advisable; also, if constipation exists, a saline purge.

I present herewith an illustrative case:

F. B., a laborer, aged thirty-three, on the 20th of June, 1891, while assisting in lowering by means of a rope an iron column, weighing about 1000 pounds, was struck above the right ear by a swinging column and thrown on his head against a four-by-four beam. He became unconscious, and, as he said when he regained consciousness after about twenty minutes, he did not know what had happened to him, having in the meanwhile been transferred to the Emergency Hospital, a distance of four blocks from the place of accident. The external evidences of injury were a scalp wound, about three inches in length, about two and a half inches above the right external auditory meatus, extending antero-posteriorly, and exposing the periosteum. The left ear was severely bruised. There was bleeding from both ears, from the nose and mouth. He also vomited blood after regaining complete consciousness. There was immediately noticed a paralysis of both sides of the face, even of the fauces. There was bilateral lagophthalmus and a convergent squint of the left eye, the pupil of which eye was also larger than that of the right, and sluggish in action.

The temporal wound was sewed up with catgut sutures, and dressed antiseptically. The nose and ears were washed with a boric-acid solution, and iodoform was blown into the ears. The man was then taken home. I called on him on the morning of June 21st. The hemorrhage still continued. He spat blood; blood came when he blew his nose slightly; and blood flowed from both ears. I again washed his nose and ears with a boric-acid solution, and blew the acid powder into his ears instead of the iodoform. He complained of severe headache and pain in the eyes, also of amblyopia of the left eye. I ordered an ice-bag to his head, and had the room darkened; I also had his nose syringed a number of times during the day. The headache continued for about five or six days, gradually diminishing until it disappeared, leaving, however, a sensation of dizziness that lasted several weeks. There was no elevation of temperature at any time. The pulse was at first somewhat retarded—60 per minute; after a few days it became from 72 to 76, and stayed there. There had been vomiting immediately after the accident, but only the single attack. The hemorrhage gradually diminished and ceased in about a week. After two weeks the syringing was discontinued. The temporal wound had completely healed by first intention, and the patient was able to sit up. The right side of the face was beginning to regain its mobility, and after three weeks the patient was able to close the right eye, and wrinkle the forehead on the right side. The left side showed no signs of improvement. I began treating it with mild currents of galvanic electricity for five minutes every other day, and although the muscles reacted well to the current, though sluggishly, there was no perceptible change after four weeks of treatment, so I discontinued it, not expecting to see that side

recover its functions. About the beginning of September the patient returned to me with an abrasion of the left cornea and an iritis, for which I sent him to Dr. Bach. I was surprised to find that he had regained considerable of the motility of the left side, and that the strabismus was disappearing. He then complained of a salty taste in the mouth, and this sensation still continues. On testing, the sense of taste is diminished most markedly on the left side, as are also the sensations of touch and pain in the tongue. The function of the seventh nerve is now almost completely, if not completely, restored; the strabismus and concomitant diplopia are gone. The man, however, complains of a weakness of vision, also of a certain deafness and ringing in the head.

Dr. Bach recently made an examination of the eyes and ears, and found the tympanic membranes intact, though there are several spots of calcareous deposit, perhaps due to extravasations at the time of injury. Hearing $\frac{3}{4}$ on both sides.

There is a general congestion of the retina, and the bloodvessels are tortuous. I do not know whether this is of both eyes or of the left only. The vision of the left eye is $\frac{1}{2}$, and of the right eye $\frac{3}{4}$. The eyes are very irritable. The lids are in a catarrhal condition, the conjunctivæ bulbi congested.

The patient says he does not feel as well now as he did a few weeks ago. The dizziness and ringing in the ears trouble him, as does also the paresthesia of the tongue.

CAUSES OF THE DIMINISHED PREVALENCE OF TYPHOID FEVER IN DENVER.¹

BY T. E. TAYLOR, B.A., M.D.,

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WHEN a disease that for several years has been widely prevalent, causing many deaths, becomes much less frequent, we naturally are led to employ much of the leisure thus afforded in investigating the causes of the change, with a view to throwing some light on the conditions favorable to the development of the specific germ of such a disease. That typhoid is less prevalent in Denver this year than in previous years is the universal testimony of the profession and is clearly shown by the records of the Arapahoe County Hospital. In 1888, up to August 15th, 62 cases were admitted. In 1889, up to the same date, 66 were admitted. In 1890, 69 were admitted, while in 1891 only 35 were admitted. The same conclusion is reached by investigating the mortality reports of the Board of Health.

To ascertain the cause of this condition, it is necessary to note the particulars in which this season has differed from others, and then we shall be in a better position to estimate the influence of each

of these variations upon the development of the specific bacillus.

The average temperature during the summer of 1891 was much lower than usual, the mean temperature during June, July, and August being only 63.4°, 68.9°, and 69.7° respectively, against 67.6°, 74.8°, and 69°, for 1890, and 62.4°, 72°, and 72.8° for 1889; the total deficiency in temperature from January 1 to August 3, 1891, being 699°.

The most noticeable peculiarity of this season was the unusual rainfall, the precipitation during the year up to and including August having been vastly beyond the average, the total excess in precipitation for the eight months from January 1st to August 31st amounting to 6.58 inches, or about 50 per cent.

Both coolness and moisture doubtless retarded the development of the germs: the former, as warmth is favorable to their growth; the latter, as the abundant rains washed away much of the accumulations of filth of all sorts that furnishes the most favorable soil for their development. Moisture probably has a further effect by raising the height of the ground-water, which this year has been much nearer the surface than usual, as is shown by the general testimony of people having wells that the water in them is much deeper than usual, and also from the fact that in north and west Denver the cellars have, in many cases, been partially filled with water.

Pettenkoffer believed that the distance of the ground-water from the surface was the most important factor in the causation of typhoid, as shown by some observations made by himself and Buhl at Munich, and repeatedly since then has it been observed that when the ground-water was far from the surface, typhoid was prevalent, and *vice versa*. No thoroughly satisfactory explanation of this fact has yet been brought forward. Baker, secretary of the Michigan State Board of Health, supposes that the contents of privy-vaults, as they soak through the soil, spread laterally as they descend, the soil so saturated forming a cone, with its apex at the surface; thus the deeper the ground-water the larger the base of this cone and the greater the number of wells that it would reach and contaminate. Whether or not this supposition can satisfactorily account for the diminished prevalence of the typhoid is doubtful. A rise of from two to six feet in the level of the ground-water would not contract the base of the cone of saturated soil to an equal extent, but even if it did, the influence of such a limited contraction could not be great, even in localities where the drinking-water is obtained from wells, as comparatively few wells would be included within this space, while it utterly fails in cases in which the water-supply is rived from streams or lakes at a distance.

The cause of present greater healthfulness, how-

¹ Read before the Arapahoe County Medical Society.

ever, must not be sought alone in these climatic peculiarities. The Department of Public Health has been much more active and efficient than heretofore, securing a more prompt removal of garbage, emptying and disinfection of cesspools, putting in thousands of sewer connections, and condemning a large number of wells. The value of these various factors can only be guessed at, but must have been considerable. This is indicated by the fact that the unsewered district, containing about two-fifths of the population, furnished during July seventy-nine deaths from all causes, while in the sewered districts, containing three-fifths of the population, there were only sixty-four deaths from all causes. During August the unsewered two-fifths furnished seventy-nine fatal cases from all causes, while the sewered three-fifths only furnished fifty-seven. I was unable to ascertain what part of these deaths was due to typhoid, but probably the proportion of deaths from typhoid to deaths from all causes was larger in the unsewered than in the sewered districts.

Also considered by wards, we find that the third, seventh, eighth, and ninth wards, which contain most of the unsewered parts of the city, furnished in July eighty-eight and in August one hundred and eleven cases, while the remaining five wards, which are sewered, furnished in July only fifty-five and in August only forty-five cases. In these districts, also, much of the water is obtained from wells, the water of which has been analyzed in many cases, and almost invariably found unfit for use.

Another possible cause may be found in the changed water-supply. Until 1891 the water was supplied by the Denver Water Company, being obtained from underground reservoirs below the bed of the Platte River, the water filtering through the sandy bottom into them. These reservoirs are situated just above the city and below the villages of Fort Logan and Littleton, the sewers of which empty into the river and contaminate the water, as the germs so introduced must be but imperfectly, if at all, removed by the filtration through a few feet of sand. This summer most of the principal streets have had the mains of the new Citizens' Water Company as well as those of the old company, and many of the houses have changed their water connections to the mains of the new company, the water of which is brought from the mountains in underground pipes, removed from any opportunity of contamination in transit. What influence, if any, this change has had upon the prevalence of typhoid, can only be conjectured. To prove anything, it would be necessary to ascertain what relation the number of cases of typhoid in houses supplied by the new company bears to the total number of houses supplied by the company, and also what relation the number of cases

in houses supplied by the old company bears to the total number of houses supplied by this company; when, by comparing these ratios it could be seen whether or not the new water-supply had diminished the prevalence of typhoid. This, however, is impracticable.

Great as is the credit due our present Health Department, I think that only a part of the improvement in the public health is due to the improved sanitary condition brought about by them, as we find a similar improvement in the surrounding cities and villages, which, of course, share with us the unusual climatic conditions, while their sanitary condition is unchanged. If our next summer shall be hot and dry, while the sanitary condition continues to improve, we shall be in much better position to estimate the value of each of these factors than we now are.

LEPROSY.

By A. LAURENT, Esq.,
OF NEW YORK.

AN article published in a leading paper some time ago concerning leprosy in Jamaica, West Indies, created quite a sensation in New York, as if the fact were a new discovery; but it must be remembered that lepers may be found in Norway, in Ireland, in Central and South America, in the Antilles, in Oceania, in Africa, and in Asia. In Europe nowadays the disease is absolutely under control, while elsewhere, beyond any doubt, it is spreading. Absolute segregation is generally considered as the best remedy, but governments experience great difficulties in enforcing the law. These difficulties are of various kinds. In extensive countries it is practically impossible to reach all the lepers. Then the question, Who is a leper? is sometimes very difficult to solve. The disease may not develop before eight, ten, fifteen, or twenty years—in case of women, often not before marriage—and the very limited knowledge concerning the disease professed by many physicians makes any step dangerous to take. Segregation also has many adversaries who, on the ground of humanitarian feelings, and looking only at one side of the question, advocate the right of man to individual liberty. Finally, and this is perhaps the point most important of all, leprosy attacks not only the poor, but many wealthy men and families suffer; and through influences manifesting themselves in various ways the latter manage to prevent any law or bill from passing, or, if enacted, to avoid its effects. That is the reason why all of the work done by several commissions appointed in England during the past fifteen years has proved sterile. Segregation, again, must be strict, general, and absolute; otherwise it is useless. In all of the reports

made on the subject, the spread of leprosy is intimately connected with vaccination with humanized virus, and this seems to explain how in Europe, where, outside of better hygienic conditions, every possible care is taken by physicians in vaccinating, the disease is disappearing, while just the reverse is taking place in other parts of the world. The following authors have furnished very important documents in support of that theory: Dr. Gairdner, of Glasgow (*Brit. Med. Journ.*, June 11, 1887), on vaccinal leprosy. Dr. F. C. Castor, of British Guiana, in his report for 1887, says that under certain conditions leprosy may be contagious, and that it is undoubtedly transmitted by heredity. Dr. John D. Hillis, in charge of the Leper Asylum of Mahaica, British Guiana, in 1889 wrote several pages to show how leprosy is being spread by inoculation (*Journ. Royal Agricultural and Commercial Society, Demerara*). Dr. Boon, of St. Kitts (*Quart. Reports* for 1889), and Governor Robinson, of Trinidad, point out the same fact. Dr. Edw. Arning, of Honolulu, in a letter to Mr. Tebb, is yet more outspoken, and says that there is no mistake about the actual synchronism of the spread of vaccine and of leprosy on the Hawaiian Islands. In another article he writes that, unquestionably, new centers of leprosy developed after vaccination was practised—leprosy, like syphilis, depending for its propagation upon the direct introduction of the virus into the blood. In 1880, Dr. Livening, of Sandwich Islands, pointing to the fact that for thirty years the disease had spread among natives of certain islands where it was previously unknown, says: "It is probable that in a certain stage of the disease it is inoculable." In a letter dated Bergen, Norway, April 9, 1889, Dr. W. G. Armour Hansen, Inspector of Leper Hospitals in Norway, says: "I moreover think that leprosy in most cases is transferred by inoculation. Whether there be any danger of transferring the disease by vaccination I cannot say, as in my country one never is vaccinated from a leprosy child, at least so far as we know." Father Damien (*The Lancet*, 1889) attributed his infection with leprosy to inoculation. Dr. Robert Pringle, of the Bengal Army, speaking of the way in which vaccination is practised in the East Indies, says that leprosy inoculation will become far more possible, and hence probable, than it may appear at present, unless prompt and stringent measures are taken in Bombay (Letter to *The Times*, June 12, 1889). Sir William Moore, surgeon-general of the Bombay staff (Lecture delivered at King's College, November 20, 1889); Dr. Herdemstam, chief medical officer for Cyprus (Letter to Parliament, March, 1890); Mr. Racker, of Barbadoes (*Agricultural Reporter*, January, 1889); Dr. J. Bechtinger, of Rio de Janeiro (book on the subject published in Vienna); Dr.

Robert Francis Black, M.R.C.S., L.R.C.P., Edinburgh; Mr. Michael MacTurck, British commissioner and resident magistrate, British Guiana; Dr. R. B. Emerson, president of the Board of Health of Honolulu, and many others, express the same opinion and give illustrative instances.

Now, knowing one and very likely the most important of all of the causes to which is attributed the spreading of the disease, why are governments so neglectful? They are well aware of the fact that lymph is never secured in sufficient quantities, and that in remote countries, outside of the physicians, many persons are practising vaccination, making use of any kind of lymph. They may do it *bona fide*, for it sometimes requires a well-educated eye to discover leprosy, above all in a child; but it would be better anyhow, under those circumstances, to prohibit any such practice. That is where the apathy of governments becomes criminal.

Venezuela is the only country where segregation is really and effectively compulsory. The law was passed during the presidency of General Guzman Blanco, and in 1880 the Providence Island Hospital was established. There, no matter who one is or what his wealth, if he be recognized to be a leper he is compelled to go to the asylum. Providence Island, about one mile long and one-third of a mile broad, is situated in the narrow part of the Lake of Maracaibo, some four miles from the town of Maracaibo, in the State of Zulia. One is not admitted to the island without a permit from the State government. Anyone that can afford it is authorized to build a little cottage on a given piece of ground. The hospital is a large rectangular building, with a large yard in the center and an inside veranda between the yard and the rooms. Everything is plain and simple, but exceedingly clean. Each room has two doors, an inside window, and its own supply of water; the walls are whitewashed; a hammock, chairs or stools, and a wooden trunk used as a press for clothes are the only pieces of furniture. About 140 lepers live on the island. The average of expenses per head per year has been brought down from \$100 in 1886 to about \$85 at present. The State of Zulia contributes 6000 bolívares (\$1200) for the maintenance of the institution. Voluntary contributions and gifts help in making improvements now and then. A chapel forms one side of the building, and a library is open to all the patients. The institution is managed in Maracaibo by a committee or junta, consisting of seven members. On the island lepers are taken care of by a physician, a chaplain, a manager, four policemen, two cooks, two boatmen, and four or five assistants.

During a sojourn of two years in Maracaibo I often went to the island, where I always found these unfortunate creatures as happy as they can be.

They are well treated, safe from ill-usage, and admit that life is made as easy for them as it can be, considering their miserable condition.

ORIGINAL LECTURES.

NON-VENEREAL SYPHILIS.

A Clinical Lecture, delivered to the Students of the Georgetown Medical College, at the Central Dispensary and Emergency Hospital, of Washington, D. C., on November 14, 1891.

BY HENRY A. ROBBINS, M.D.

LAST week we had the difficulties in the diagnosis of syphilis under consideration. The more you see of syphilis the more you will agree with that Scotch divine who, commenting on the text "David said in his haste, all men are liars," said: "Ah, David! if you had lived at the present time, you would have said that at your leisure."

Years ago it was supposed that syphilis was exclusively a venereal disease, and that the poison was always transmitted by carnal contact. It is well known at the present time, however, that syphilis occurs very frequently from inoculation during operations, from innocent exposure of the lips to the poison by kissing, and other methods equally consistent with the good character of the person affected.

Some years ago, Dr. Bulkley, of New York, read a paper before the New York Academy of Medicine, in which he drew the following conclusions:

"Syphilis is not necessarily a venereal disease, but in a considerable proportion of cases is acquired quite unconsciously, and in an entirely unexpected manner. Failure to obtain a venereal history should not lead to the conclusion that certain lesions are not those of syphilis. The syphilitic virus can be carried a long distance, and after some time cause syphilis in the inoculated. Non-venereal chancres have been mistaken for epitheliomata, and operations for their removal have even been performed. Non-venereal syphilis often shows great malignancy."

A week ago I gave at length a report of the case of a little girl, seven years old, who acquired syphilis in a singular way. After accidentally injuring her hand, suffering an incised wound, her uncle put his mouth to the part, thinking that suction would more rapidly induce healing. A chancre, followed by enlarged glands of the axilla and roseola, ensued. Examination of the uncle revealed mucous patches in his mouth.

I alluded to another case occurring in a Jewish family in which, after the rabbi had performed the religious rite of circumcision on a child, a chancre developed, and subsequently mucous patches were discovered in the mouth of the rabbi.

Dr. M. Rollet, in a chapter of his excellent work on syphilis, mentions the frequent transmission of this disease among workers in glass, who, in blowing bottles, make use of an iron tube, called a *canné*, which passes from mouth to mouth; in consequence of this practice, infections take place, commencing in the mouth.

Dr. M. Hillariet mentions the case of a patient, a lady

whose morality was above suspicion, who acquired a chancre of the lower lip, followed by terrible constitutional syphilis. She had drunk from a glass that had been previously used by a woman who was affected by a chancre of the lip. Dr. Hillariet also mentions the case of a favorite medical student who acquired a labial chancre by placing between his lips a pen that had been soiled by his own fingers, previously in contact with ulcerations.

It is a well-known fact that in Cuba the most expensive cigars carry chancre-poison, having been licked with the lips by the roller to make the ends secure. Perhaps this fact may solve the question of the origin of *epithelioma* when the diagnosis and prognosis of certain cases have been so vague and unsatisfactory. I quote the following taken from the *Times*: "A prominent physician told me lately, that from the practice of cigarmakers wetting the wrapper with saliva and biting the end of the cigar into shape, a spread of syphilitic disease was taking place; that he knew of several cases. Somewhat alarmed, I managed to visit a number of factories. Two-thirds of the cigarmakers, I found, daub the whole end of the cigar with their saliva. Thinking that Cuban workmen might not do it, I visited places where they were employed, finding that not only did they use their saliva to make the wrappers stick, but that most of them, before wrapping, bit the end of the cigar into shape with their teeth."

At a clinic held in Paris, at the Hospital St. Louis, Dr. Fournier presented a man who had an indurated chancre of the tonsil, followed by engorgement of the cervical glands and secondary eruptions on the skin. The primary chancre was evidently induced by a simple cauterization with a stick of nitrate of silver which had previously been used on a chancre. In a similar manner Dr. M. Blanchet, who had a large practice in Paris, communicated syphilis to twenty-seven persons in passing a catheter into the Eustachian tube; among others, a young girl of high connections, a pupil of *Sacre-Cœur*, was infected, and, together with other symptoms, suffered from necrosis of bones of the nose, but recovered good health subsequently. Blanchet had the habit of simply placing the catheter in a tumbler of water after each catheterization, without otherwise cleansing it.

The *University Medical Gazette* says that "the initial lesion of syphilis has been reported a number of times in the literature of medicine as occurring on the eyelids, most frequently upon the free border of the under lid, and at both commissures. The source of infection has usually been due to kissing, a mucous patch in the mouth being the source of the contagion. Chancres have not alone been found in the eyes of adults, but are occasionally found in children. Thus, in an analysis of twenty-one cases of syphilitic lesions of the eyelids made by Griffith (*Medical Chronicle*, 1886), five children of thirteen months or under were affected: in four of them the manifestation was primary, and in one the appearance exactly simulated that of a Hunterian chancre, although the reporter was not able to definitely prove this point. A number of instances of chancres appearing among children in France some years ago led Baudry to investigate the source of infection. This was found in the not infrequent custom among the attendants of these children of attempting to cure inflamed

eyelids by moistening them with saliva. Mucous patches were present in the mouths of these attendants, and the palpebral borders were thus inoculated with syphilitic poison. It is a fact not generally known, perhaps, that among certain ignorant and filthy classes the habit of endeavoring to remove foreign bodies from the eye by means of the tip of the tongue is not an uncommon practice."

Dr. Motz (*Gazette des Hôpitaux*, 128) reports the case of a soldier having an indurated chancre of the eyelid. Under specific treatment recovery took place in nine weeks. A kiss was supposed to have been the cause.

Dr. Lee (*Liverpool Medical and Surgical Journal*, January, 1886) reports the following: "A man had a chancre on the left upper eyelid, accompanied by considerable swelling and induration of the pre-auricular and submaxillary glands on the same side. The patient was strong and healthy, married, aged about thirty-five, a laborer in the Mersey tunnel, and stated that six weeks previously he had gotten some grit in his left eye, which a fellow-workman undertook to remove by licking with his tongue. About a month after this occurrence the eyelid commenced to swell; there had been no discharge from it, and shortly he noticed that a lump began to form on the side of his cheek; he used only domestic remedies, and the eyelid not improving in about a fortnight, he sought advice at the infirmary. Specific treatment resulted in cure.

I have, in my medical scrap-book, notes of several cases of syphilis communicated through the medium of a razor during the process of shaving. I have also found a case of acquired syphilis from the bite of a man. Dr. MacLaren, in his splendid *Atlas of Venereal Diseases*, has a beautiful representation of a digital chancre caused by striking in the mouth a man who was a victim of syphilis, and had buccal mucous patches.

Before bovine virus came into general use, syphilitic virus was undoubtedly communicated through the agency of humanized virus. The literature on this subject is voluminous. Chancres probably resulting from the lascivious kisses of an infected prostitute can be found almost anywhere on the integumentary surface.

The following case is unique: Dr. Leloir (*Annales de Dermatologie et Syphilis*, 1882, Nos. 9 and 10) relates the case of a medical student in whom the initial manifestation of syphilis was situated between the second and third toes of the right foot. The patient was suffering from eczematous fissures between the toes, and acknowledged contact of the affected part with the lips of a woman who was afterward found to be suffering from mucous patches of the mouth.

The following I quote from the *Gazette des Hôpitaux*, December, 1859: Dr. Guényot and M. Gailleton were prosecuted at Lyons for inoculating a child, not affected with syphilis, with secondary syphilitic pus. The inoculation was successful; secondary syphilitic symptoms appeared within two months. They were fined for the experiment, one in the sum of 100 francs, the other in the sum of 50 francs.

Otis says that mediate contagion of syphilis is common. "It may be through the medium of a spoon, a pencil, a cane, a cigar, a kiss, or dental instruments. The accoucheur may acquire it through his finger. Nine cases of syphilis of the finger I published several years

since as occurring under my own observation, and I have seen other cases since that time. Besides this, I have seen at least double that number of cases of syphilis where no possible trace of source of contagion could be ascertained. A tumbler, or any article in common use, defiled with the secretions of a mouth harboring a mucous patch, coming in contact with a crack or abrasion of the lips of a healthy person, may communicate syphilis through a resulting lesion, which may pass away unnoticed. Any similar contact with the blood of a person in the active stage of syphilis will communicate it."

Years ago, there was a question whether the blood of syphilitics was contagious or not. To solve this question, Dr. Bargioni, an Italian physician, voluntarily submitted to the experiment. The patient who afforded the material for experiment was a woman, aged twenty-five years, the subject of well-marked constitutional syphilis. Her arm was washed clean, and no eruption existed on that part. The cephalic vein was opened, and some blood was drawn; lint was dipped in it, and applied to the arm of Dr. Bargioni, in which three incisions had been made, just below the insertion of the deltoid. In twenty-four hours the lint was removed. In four days all trace of the inoculation was gone. After a few days he noticed itching, and on looking at the arm there was observed a round papule, of a red color, but no induration around it. The papule gradually increased, and in eight days was of some size, and covered with a slimy scale. Eleven days after its first appearance the glands in the axilla became enlarged. On the sixteenth day these glands were larger; and on removing the scab from the papule a small quantity of serum was found beneath, but no induration around it. On the eighteenth day, there was an ulcerated surface with a crust on it, and a certain degree of hardness at its borders. On the twenty-third day it was larger and harder, as were also the glands. A month after the first appearance of the papule he had nocturnal pains in the head, and observed some enlargement of the cervical glands. A week after this a roseolous rash appeared on the body, and spread all over him, leaving no doubt as to its nature. In another week the sore was not yet disposed to heal, and the glands were larger. The rash then became copper-colored. Mercury was given, and the sore began to heal.

I will now proceed to report some cases in which, as physicians and surgeons, we are more especially interested.

Dr. Wilks, of Guy's Hospital, reports the case of a surgeon who accidentally cut his finger while operating on a man suffering from secondary symptoms, and who himself in consequence took the disease. This surgeon gave it as his opinion that women continue to infect men long after the primary sore has healed.

Diday speaks of the frightful ravages of syphilis in a country village, introduced by a syphilitic infant and propagated by the nurse.

Chancre of the breast is one of the most important of extra-genital chancres. Although it may be contracted by contact with the mouth, or even the genitals of another adult, it is by far the most frequently met with as the result of contagion from mucous patches on the lips of nursing infants.

When attending the clinics at the Allgemeine Krank-

enhaus in Vienna during the years 1877, 1878, and 1879, I attended several "semesters" of Professor Zeissel, one of the greatest syphilographers of the age. This pre-eminent man, we all know, had acquired syphilis while opening a bubo. During the year 1884 he died of cerebral syphilis.

It would be impossible for pen to portray the dangers and horrors of syphilitic infection more graphically than Professor Wm. Goodell has done in a clinical lecture to his students at the University of Pennsylvania. Dr. Goodell says:

"When I was a medical student, one of the members of my class, just before his final examination, broke out, from head to foot, with an unmistakable syphilitic eruption. He was at a loss to account for it, yet his diploma was at first withheld from him, on the ground of immoral conduct. Fortunately he remembered having had a sluggish ulcer on his finger, which, very luckily, he had shown to a member of the faculty, who, however, made light of it. This fact, together with the fact that he had worked during the summer vacation in the venereal wards of a hospital, exonerated him. His diploma was given to him, but he was too much disfigured to go on the stage to receive it. Now mark the history of this man! After taking much medicine, and supposing himself cured, he settled in a Western city, and married. To his great dismay, the first pregnancies successively ended in early miscarriages. Then he put himself and his wife upon a long course of specific treatment. The pregnancy that followed this went nearly to term, and husband and wife were very happy. But the curse was yet upon him. She was prematurely delivered of a syphilitic and dead child. Terribly disappointed and disheartened, the doctor fled from his wife's bedside to an upper room of the house, and shot himself dead.

"I often met in consultation a physician of fine physique, and in splendid health. Unfortunately he delivered a woman whose husband had infected her. That physician is now a wreck, dragging one foot behind him as he hobbles on crutches. It was the old story: first a sluggish and unsuspected sore upon the hand, and next the characteristic eruption, which, like a thunderbolt, revealed the nature of the disease to the unfortunate victim. Then a gummy tumor formed in the brain, followed by aphasia and paresis. Potassium iodide in heroic doses saved his life, but that was about all it did.

"I know two other physicians who caught this horrible disease while in the discharge of their professional duties. One of them lost every hair on his body, from the crown of his head to the sole of his foot. For years he struggled and strove with the poison. But he finally conquered it, and lived to marry, and to have a family of healthy children around him. The other physician had the usual innocent-looking sore on his finger. It hung on obstinately, and for weeks he had his finger in a stall, yet I could not get him to believe that it was specific. Before long he was confined to his house with some obscure chest-trouble, which greatly perplexed his physicians. I could not stand it any longer, and going uninvited to his bedroom I made a strong 'deliverance' of my opinion of his disease. But he laughed me to scorn. A few days later, a magnificent crop of rupia appeared upon his forehead. Then all was clear; and

under appropriate treatment he recovered his health and has continued well ever since, but he was ill for a long time.

"The knowledge of these facts has made me keenly alive to the dangers which physicians in general, gynecologists especially, incur in the examination and in the delivery of women. It has also made me very careful to see that all my everyday instruments are kept scrupulously clean, for there is no doubt that careless physicians have unwittingly inoculated their patients by their instruments, and especially by the speculum. Why physicians who contract this disease in the legitimate exercise of their duties should, as a rule, suffer more than those who pay penalty for their immorality, I can explain only in one way. In the former the sore is ectopic, and not being in the usual site, is not recognized early enough to be controlled by local and constitutional treatment. In the immoral, the chancre usually appears on the genital organs, where it is anxiously looked for, and where its identity is unmistakable."

**PSORIASIS—ACNE ROSACEA—EPITHELIOMA—
TINEA FAVOSA—SYCOSIS—HYPER-
IDROSIS.**

A Clinical Lecture.

By LOUIS A. DUHRING, M.D.,

PROFESSOR OF SKIN DISEASES AT THE UNIVERSITY HOSPITAL.

CASE I. Psoriasis.—This man, thirty-five years of age, has been affected twenty years, but never seriously, until after an attack of influenza one year ago. His body and scalp show numerous disseminated, scaly, slightly inflamed, erythematous, ill-defined patches, with considerable thickened skin. There are several patches, about the size of a dollar, on the back, and two or three palm-sized patches on his chest, tending to run together. The latter are yellowish, and more inflamed than the others, as a result of the application of chrysarobin ointment. The discoloration and inflammation caused by chrysarobin constitute the great objection to its use, since both skin and clothing are stained, besides setting up an artificial inflammation, unless cautiously and skilfully used. It is a most valuable remedy in this and other skin diseases, and these disadvantages may, in part, be overcome by care; use it sparingly, and not too strong at first, from 5 to 15 grains to the ounce, cautioning the patient as to its properties and dangers. With these precautions, it forms the best local treatment at our command. In this patient, on whom it was used in the proportion of 20 grains to the ounce, the scales have disappeared, and he is already much improved, though the skin is slightly discolored. Small blackish points are observed on his body, due to the staining effect upon the contents of the sebaceous glands. To allay the inflammation the following formula will be ordered:

R.—Acid. boric. ℥ij.
Zinci sulph. gr. ij.
Alcoholis f ʒj.
Aque q. s. ad f ʒiv.—M.
S.—Apply three or four times daily.

After subsidence of the inflammation, we will return to the use of chrysarobin. When psoriasis is localized, external treatment alone should, in most cases, be used;

though, in some cases, constitutional treatment will prove advantageous. Relapses are the rule, but patients sometimes escape. Seborrhea of the scalp differs from this disease, in that it is generally more diffused, and does not present the infiltration of the skin that occurs in psoriasis.

CASE II. Psoriasis.—This woman is also suffering from psoriasis. On one leg we notice small, red, circumscribed, and slightly scaly spots, while on the other leg there is a large, indurated, fissured, and inflamed lesion, showing no signs of the characteristic scales, and which, but for the existence of the lesions on the other leg, might be diagnosed eczema. The disease has existed for two months, and has had no treatment. Remedies of different strengths are required for the two legs. For the small lesion an ointment of chrysarobin, 15 grains to the ounce, will be ordered; while for the larger, as it is fissured and inflamed, the following ointment will, for the present, be ordered:

R.—Acid. salicylici gr. xij.
Zinci oxidi 3jss.
Petrolati 3j.—M.

CASE III. Acne rosacea.—This woman, aged thirty-five years, who is large and stout, has been under treatment for several months, and is much improved. Some cases of this kind are easily relieved, while others are extremely obstinate. It is a compound disease made up of acne plus dilatation of the capillaries, or rosacea.

There exists a disturbance not only of the secretion of the glands, but also of the circulation around the glands.

Treatment, in ordinary cases, is much the same as in acne. The following has been used:

R.—Ung. sulphur. . . . 3j.
Resorcin. . . . 3ss.
Acid. salicylici gr. xx.—M.

It does not irritate, but improvement is now not so marked as formerly, hence we will continue the foregoing at night, and order the following lotion to be used in the morning:

R.—Sulphur. precip. . . . 3j.
Etheris f3vj.
Aq. Cologn. . . . f3iv.
Alcoholis q. s. ad f3iv.—M.

S.—To be shaken and applied for fifteen minutes each morning.

This treatment will be continued for several days. The lotion is a valuable formula, in some cases proving of more benefit than any other remedy. The method of combining remedies, by using dissimilar ones night and morning, is frequently found to be of distinct advantage. Then, too, much may be accomplished by properly directing a patient, and particularly in acne is this true. Patients should be made familiar with the method of using a remedy, whether to be applied with or without friction, the length of time to rub in an application, etc. Frequently, when this is neglected, we find patients not carrying out the treatment properly, thus at times explaining the failure of good remedies. If the case be a marked one, the patient should be seen often, and the progress of the disease watched under treatment.

CASE IV. Disseminated glandular epitheliomatous degeneration on the neck.—The patient, an elderly man, states that these lesions have been forming for fifteen or twenty years. The disease is a superficial, epithelial degeneration, disseminated, breaking down in places, forming small ulcers. It is the mildest manifestation of epithelioma, and may continue in this way for years, or it may break down into larger and more active lesions, if allowed to pursue its natural course. Much may be done for this mild expression of the disease. An ointment of sulphur, at first 30 grains to the ounce, and later stronger, will be ordered, to be rubbed in twice daily. Sulphur soap may be used in place of ordinary soap. Resorcin is also useful in these cases. This treatment tends to arrest the abnormal epithelial proliferation.

CASE V. Epithelioma of the nose.—This woman, sixty-five years of age, had a dime-sized ulcer on the side of her nose, which was curetted four weeks ago. The wound has since been healing. She has been using a dressing of resorcin cerate, 30 grains to the ounce, which was found to be too stimulating and was discontinued. Resin cerate was then ordered, and has proved beneficial. Granulation should not be allowed to cease too soon, or the resulting scar will not be full and shapely. The wound is now discharging freely, and we will endeavor to keep up granulation by using a wash of resorcin, 20 grains to the ounce.

CASE VI. Tinea favosa of the scalp.—This boy, an Italian, ten years of age, has a contagious, parasitic disease of the scalp, characterized by small, cup-shaped, pale-yellowish crusts, each perforated by a hair. The crusts increase in size, forming irregular-shaped masses, which have a peculiar, characteristic, mouse-like odor. The hairs become much diseased, dry, and brittle, or the follicles suppurate, and the hairs fall out, leaving scars. The disease is only occasionally met with in this country. It usually occurs among the poorest class, and chiefly in foreigners.

Treatment is difficult when the disease is extensive. It pursues a decidedly chronic course, lasting for years or for a life-time. This boy has been using the following as a soap:

R.—Sulphur. . . . 3ij.
Acid. salicylici gr. xxv.
Soft-soap 3j.—M.

Besides this, he is applying a wash of sulphurous acid, and the officinal sulphur ointment, under which treatment he is somewhat improved. The disadvantage of treating this disease lies in the fact that it is found in this class of people; it is extremely difficult to have a line of treatment thoroughly carried out. An ointment of betanaphthol, 3j to the ounce, is useful, and in this case will be prescribed at an early day.

CASE VII. Sycosis.—The lesion, on this man, has existed for four months, and consists of papules and papulopustules, each perforated by a hair, together with marked thickening and inflammation, involving the bearded region of the face. This disease is met with in all grades of society. The lesions appear close together, and tend to set up an area of follicular inflammation, accompanied usually with burning. In tinea sycosis the hairs are soon involved, becoming dry, brittle, and loose,

falling out spontaneously, or they may be readily extracted. Tinea sycosis, moreover, usually pursues a more rapid course. Sometimes it is difficult to distinguish between the affections without the aid of the microscope. The disease is obstinate, and must be properly treated. This man has a subacute type, which calls for stimulating remedies, such as the following:

R.—Zinci sulphatis } aa . . . grs. x.
Potass. sulphidi }
Aquæ f ʒiv.—M.

S.—Apply to face three or four times a day, for a few days.

After which use sulphur ointment (ʒij to the ounce), rubbed in with friction. The face should be shaved every other day. Ichthyol and resorcin, in form of lotion or ointment, may be used locally with advantage. Constitutional treatment, as a rule, is of little value. Some cases require stronger and more penetrating remedies, as salicylic acid with sulphur ointment. Never aggravate the disease by remedies, and as soon as increased inflammation sets in, stop the remedy. If the treatment being used does not show improvement in three or four days, it is advisable to make a change.

CASE VIII. *Hyperidrosis of the soles*.—The plantar surfaces of this young man's foot have been affected for six or eight years. It is a functional disease of the sweat glands, and is usually chronic. Bromidrosis, or stinking sweat, is at times present, and may be so marked that the patient cannot occupy the same room with other persons. Astringent lotions and dusting powders are indicated. The patient has, for the past week, been dusting with boric acid, after washing the feet several times each day and thoroughly drying, and returns to-day greatly improved.

CLINICAL MEMORANDA.

A CASE OF IMPERFORATE ANUS; SUCCESSFUL OPERATION THROUGH PERINEUM.

BY ALFRED E. BRADLEY,
FIRST LIEUTENANT AND ASSISTANT SURGEON, U. S. A.

BABY F., a female, was born July 22, 1891, at midnight. On the following day it was noticed that the infant had no anus. The child was sent to the writer through the kindness of Dr. F. A. Halliday, Acting Assistant Surgeon U. S. A., whose case it was. No tumor or fluctuation could be found; abdominal pressure caused no bulging, and in no way could the presence of the bowel be determined. The perineum was smooth, the raphe extended from the vulva to the coccyx; not even a dimple marked the anal site. The genital organs were apparently perfectly developed; urination was normal; the infant was fairly well developed, but was irritable, and evidently in distress; the abdomen was distended, and the superficial veins passing to the anterior thorax were prominent and tortuous. The child had taken the breast, but was loth to do so for some twenty-four hours prior to the operation; vomiting had taken place several times, but consisted only of the milk taken. Its weight was not more than six pounds, and it was not particularly well nourished.

An operation through the perineum was decided upon, and was agreed to by the parents. If the perineal route had failed, preparations had been made to do an inguinal colotomy.

The child was placed in the lithotomy position, and, with the assistance of Dr. Halliday, the operation was performed on the morning of July 25th, the child being then fifty-eight hours old. No anesthetic was given; the only pain the infant seemed to experience was while the incision was being carried through the skin. This incision was about seven-eighths of an inch in length, and made antero-posteriorly. Dissection in the line of the coccygeal and sacral curve was carefully and cautiously made with scalpel, grooved director, and probe-pointed scissors, the little finger being employed as a probe. After going in to the depth of about an inch, an exploring-needle was carefully used; after its introduction about an inch further the escape of gas showed that the bowel had been punctured, and that the operation could be carried on with probable success. Further dissection to a total depth of about two inches disclosed the rectal pouch distended at the bottom of the incision. It was grasped by forceps, a tenaculum introduced, and the bowel then opened by an incision about half an inch long. This was followed by a gush of meconium and some gas. The quantity voided seemed enormous, and the relief given the infant was immediately evidenced by a quiet sleep.

The incision and lower bowel having been cleansed by injecting warm water, the rectum was carefully drawn down by the tenaculum and sutures introduced. The first was passed through the margin of the perineal incision, through both lateral walls of the rectal pouch, and out through the margin of the incision on the other side. When the loop in the lumen of the rectum was drawn down and divided, the bowel could be easily manipulated by the two lateral sutures thus formed. As nearly as possible the edges of the incision into the rectum were brought into apposition with the incision through the skin, and the sutures tied. In, all seven sutures were thus introduced, and the rectum was then continuous with the perineal opening. This opening was much diminished in size by the slight upward traction of the bowel, but mostly by the action of the external sphincter, which threw the tissues about the incision into distinct corrugations. Throughout the operation the writer was impressed with the tremendous size of his hands and instruments as compared with the extremely small field of operation. The child stood the operation well; there was no evidence of shock or collapse; it went quietly to sleep, and after awakening it took the breast eagerly.

On July 30th, though there had been previously a slight diarrhea, there were but two passages, beginning to be normal in appearance. The stitches all pulled out from the bowel; there were no adhesions of the bowel to the skin. The wound looked healthy, and granulations were springing up. The bowel was adherent at a point about three-fourths of an inch above the perineal incision. The child suckled heartily, slept well, and its condition was in every way favorable. The wound was dusted with equal parts of iodoform and boric acid.

On August 2d the child was still doing well, suckling, sleeping, and thriving. There appeared to be some in-

continence, but there was still certain control over the sphincter. The parts were healthy. A rectal bougie of tallow, about two inches long, was introduced twice daily to overcome the tendency to cicatricial narrowing.

On September 20th the child was growing and thriving, with two or more healthy passages each day. Cicatricial hardening and contraction had taken place, so that it was difficult to introduce even the tip of the little finger. The resisting ring seemed firm and fibrous. Tallow bougies were used, but of too small diameter. A tight fitting bougie caused considerable pain. Bougies five-eighths of an inch in diameter at the base were slowly introduced and allowed to remain about five minutes. These were to be gradually increased in diameter until the desired result was obtained. If these should prove ineffectual, the ring of narrowing should be nicked by a scalpel, and gradual dilatation be maintained during and after the healing.

On December 18, 1891, when last seen, the child was doing remarkably well. It had been necessary to dilate the cicatrix on account of the extreme contraction; this was done under chloroform, the narrowed ring being nicked by a scalpel in several places, and this followed by forcible dilatation with the little finger. There had been considerable reaction, and for a few days it seemed that recovery would be impossible. Healing took place, however, and the perineal opening became much more patulous, and, though narrow, it seemed to be sufficient. The bougies were still employed, for the tendency to narrowing still existed. The child was large and healthy, but it was with difficulty kept free from constipation, and required constant watching. There seemed to be little or no incontinence.

FIBROID TUMOR OF THE UTERUS.

BY W. H. MILLER, M.D.,
OF LITTLE ROCK, ARK.

CALLED to see Mary M., a colored woman, forty-three years old, married and the mother of three children, I learned that she had not menstruated for ten months or a year, and that she was having excessive hemorrhage from the vagina. Upon examination, I found a tumor in the vagina, about the size of the normal uterus, tightly grasped between the lips of the cervix.

I introduced a speculum, and ascertained that the hemorrhage came from the tumor, which had all the appearances of a fibroid of the uterus. I succeeded in checking the hemorrhage with tampons moistened with hydrastis; these I allowed to remain in the vagina for twenty-four hours, when I removed them and found the hemorrhage but slight. Inversion of the uterus had been diagnosed; repeated attempts had been made to replace the mass, but had proved unsuccessful. For purposes of confirmation or correction, I attempted to pass a sound into the uterus. The procedure was attended with difficulty, on account of the extensive base of the tumor; but, once finding an opening into the uterus, the sound was readily passed for nearly three inches. I was thus fully satisfied that the condition was not one of inversion of the uterus. The tumor was hard and non-painful, bleeding freely when punctured. The patient's family history was good; she said that about

eight years previously she had been operated upon for a tumor in the same situation, and that the growth was not entirely removed. I, therefore, concluded that the mass must be a fibroid tumor of the uterus.

The tumor could not be moved from side to side, as is the case with pedunculated fibroids; hence I concluded that it must have a broad base; this opinion I afterward found to be correct, as the attachment of the tumor extended from just within the external os to the fundus of the uterus, and laterally about two fingers' breadth.

I prescribed fluid extract of ergot, *ʒij*, *per rectum*, three times a day, to prevent a recurrence of the hemorrhage, and to facilitate expulsion of the tumor, which I determined to remove as soon as possible. I was compelled to delay operation for some time on account of the development of an acute phlebitis in the left lower extremity. The tumor seemed to diminish in size and become softer, and there was a slight discharge from the uterus. The patient had some fever, which was controlled by irrigation of the uterus with hot water and bichloride of mercury.

On June 13th, with the assistance of Drs. Lindsay and Dickinson, I operated on the patient in the Sims position; and with the Sims speculum in the vagina I attempted to pull the tumor down, but failed on account of extensive adhesions of the uterus. I then passed a shawl-pin through the tumor to prevent the wire of the *écraseur* from slipping. I attempted to pass the *écraseur* around the tumor, but failed on account of the large extent of attachment. Using the fingers of the left hand in the vagina as a guide and to prevent injury to the uterus, with a pair of curved scissors I cut into the capsule of the tumor at its attachment to the wall of the uterus and enucleated the growth. The hemorrhage was slight, and after removing, by means of the curette, such particles as remained, I packed the uterus with iodoform cotton, and placed the patient in bed. Recovery was prompt and satisfactory. The woman's general condition improved greatly; her stomach, which previously to the operation had been irritable, gave her no further trouble. Previously to the operation the patient was confined to bed; the repeated hemorrhages had rendered her anemic. She now goes about attending to her household duties, and says that she feels better than she has for years. The cavity of the uterus measures about three inches in length; the os is about normal. The woman menstruates regularly, the period lasting about two days; it is free from pain, and the flow is not excessive.

I am aware that there is nothing new or novel in the case that I have reported. Perhaps the treatment may be criticised by electricians, who may say that I should have tried electricity before resorting to an operation. I think that electricity may be beneficial in cases of intramural fibroids when the growths cannot be removed without at the same time removing more or less of the uterus, or otherwise injuring that organ; but in all cases in which the tumor is accessible I should resort to the more certain procedure of immediate enucleation.

It may be suggested that with a woman forty or forty-five years of age an operation was not indicated, but that the menopause should have been awaited; but the condition of the patient was such that delay would have

been dangerous. In the next place, fibroids tend to defer the menopause.

A large fibroid tumor occupying the vagina may readily be mistaken for an inversion of the uterus. If in a non-corpulent person there should be an inversion of the uterus, we usually find a cup-shaped depression in the space behind the pubes usually occupied by the normal uterus; while in case of fibroid tumor palpation will disclose the presence of a uterus rather larger than normal. By rotating the tumor, if it be pedunculated, we find that the uterus rotates but little or not at all. The diagnostic point is the introduction of the sound. If in a case of long standing we can pass the sound through the cervix and beyond the mass in the vagina for a distance of two or three inches, we can say, without fear of contradiction, that the case is one of fibroid tumor, and not of inverted uterus.

I remember a striking case in which a mulatto woman presented a large tumor completely filling the vagina. Upon being directed to stand up and to bear down, she succeeded in completely expelling the tumor, which was an inverted uterus of long standing, which extended about half-way to the knees.

PAPILLIFEROUS FIBRO-CYSTIC ADENOMA OF ABERRANT BREAST NODULE.

BY W. S. FORBES, M.D.,
PROFESSOR OF ANATOMY IN THE JEFFERSON MEDICAL COLLEGE
OF PHILADELPHIA.

THIS comparatively rare form of tumor was taken from a patient brought to me by Dr. Wm. Harris, of Hamburg, Pa.

Mrs. S., forty-eight years old, when married, at the age of twenty-eight years, weighed 128 pounds. She now weighs 385 pounds. She has a younger sister who weighs 300 pounds, and who has borne two children, now young women, of twenty-two and twenty-four years of age. Mrs. S. has never been pregnant; she has always menstruated with regularity, without trouble, and continues to do so.

When examined December 18, 1891, a tumor was found in the left upper quadrant of the left breast. Both breasts were huge and pendulous.

The patient had observed a lump in the left breast for ten years, but only in the last twelve months had it begun to enlarge. The tumor appeared to be a fibroma lodged in a mass of fat, having no bands binding it either to the pectoral wall or to the mammary gland. After extirpation there appeared at least three inches of fat between the tumor and the mammary gland, and about the same thickness of fat between the tumor and the middle of the lower border of the neighboring great pectoral muscle.

There was no difficulty in removing the tumor. The patient returned to her home in ten days perfectly well.

I asked Dr. Coplin, Demonstrator of Pathological Anatomy in the Jefferson Medical College, to examine the specimen. The following is his report:

The tumor is irregular in outline, the sides and borders covered by fat. Its weight is 109 grams (nearly 3½ ounces), and it measures in its longest axis 8.5 cm. (3 inches), in width 6.5 cm. (2½ inches), in thickness 4.5 cm. (1½ inches). Upon section it cuts hard

and creaks slightly under the knife. The cut surface shows several small cysts, varying in diameter from 0.5 mm. to 2 mm. Their outline is regular; some are round, some ellipsoidal, and a few semilunar, with projecting masses extending into, and entirely filling, the cavity. Where any fluid is present it is clear and viscid, closely resembling egg-albumin. Sections made through different planes show these cysts to be restricted to an area slightly oblong, and about 3 cm. (1¼ inches) in diameter. This mass constitutes the tumor proper, with outlying bands of fibrous tissue.

Microscopic examination shows these cysts to be lined by cylindrical-celled epithelium, the masses projecting into the cysts being dendritic in character, with, in some, the appearance of branching. The stroma is a hard, dense, fibrous tissue, with here and there well-marked, but poorly developed, acinous-gland nodules, varying from one to three acini, their walls lined by flattened and poorly developed epithelium. The vascular supply to the growth has been abundant, and into some of the cysts hemorrhage has taken place.

The tumor is a papilliferous fibro-cystadenoma, a comparatively infrequent tumor of the breast. Among my sections I have a slide of an identical tumor. The late Prof. S. W. Gross brought the slide from abroad. These are the only specimens of this form of fibro-adenoma that I have seen.

From the position of the tumor and its histology I infer that it is from an aberrant breast nodule. These are not so rare as we are often led to believe, and when present are extremely liable to the development of neoplasms, for the most part malignant in character. I have a photograph of a case of carcinoma of aberrant breast nodule from a case at the clinic of the Jefferson Medical College Hospital several years ago. When the tumor was removed I found that it had no histologic connection with the mammary gland proper, which had been removed as a precautionary measure. The nearest gland lobule to the growth was fully two inches from the neoplasm, sections of which not only demonstrated, as in this case, the presence of gland tissue, but also that the entire aberrant breast had not been invaded by the neoplasm.

I have examined three cases of outlying breast structure, and all, strange to say, on the left side.

CHRONIC OTITIS AND ABSCESS OF THE TIBIA OF LONG STANDING.

BY G. FRANK LYDSTON, M.D.,
OF CHICAGO, ILL.

THE following case appears to me a most interesting one, as showing the prolonged duration of chronic inflammation of bone, and the liability to the intercurrent formation of abscess.

The patient, a gentleman forty years of age, suffered a fracture of the tibia when seven years of age. Whether the fracture was compound or not he does not know, but I infer from his history that it was. It was followed by severe inflammation and necrosis of a portion of the bone. Ever since this early accident, he from time to time has experienced more or less pain at the site of the fracture, which was near the junction of the lower with the middle third of the tibia, and slight

pressure has always been sufficient to make him wince. He states that ever since the accident the lower portion of the bone has been quite tender, and has troubled him a great deal during change of weather. About six years ago he began to have pain in the upper portion of the tibia, principally marked at the articular extremity; more or less swelling was perceptible, and has continued to the present time. There have been occasional exacerbations, with quite acute pain. There is no history of syphilis, or any infectious disease, save scarlet fever in his youth. During the exacerbations of pain and swelling the patient has been compelled to use crutches. Within the last few weeks the pain has been exceptionally severe, and the difficulty of locomotion more marked than at any previous time.

At present the entire tibia is swollen, its diameter being fully double the normal; the muscles of the limb are atrophied from disuse, and possibly the reflex effect of the osseous inflammation and consequent disturbance of nutrition; there is excessive tenderness over the tibia, particularly marked at its upper and inner aspect. In this situation a marked nodular swelling exists, indicating a subperiosteal bony deposit. Another spot of a similar character is discoverable near the site of the old fracture. Numerous cicatrices adherent to the bone are present over the anterior surface of the tibia at points from which the patient says dead bone has been removed, or has escaped spontaneously from time to time.

The diagnosis is chronic osteitis, with osteo-sclerosis of considerable extent, and a probable abscess (possibly a sequestrum) in the upper cancellous extremity of the bone.

A free incision was made in the entire length of the tibia. The periosteum was found greatly thickened throughout. Subperiosteal nodes were discovered at the site of the thickening described; these were perceptible before the operation. The periosteum was peeled back and the bone exposed, and found to be of the peculiar ivory-like consistency and appearance characteristic of osteo-sclerosis. After considerable gouging and chiselling through the hard, ivory-like structure, an abscess was exposed in the upper extremity of the bone, which contained about a tablespoonful of moderately thick pus and was lined with a thin layer of granulations, and was evidently of quite recent formation. This abscess was probably tuberculous. No examination for bacilli was made, however. It was probably the result of a secondary tuberculous infection. The cavity was thoroughly cleaned out, and the bone drilled with a small drill in various directions surrounding the cavity. A linear osteotomy was performed through the lower portion of the bone, and the subperiosteal nodes thoroughly chiselled away, with removal of enough of the ivory-like bone beneath them to insure repair. The cavity is filling up nicely, and the pain is completely relieved. The result, undoubtedly, will be restoration of the limb to its normal degree of usefulness.

DIAGNOSIS OF FRACTURE OF THE FEMUR.

By W. M. L. COPLIN, M.D.,

DEMONSTRATOR OF PATHOLOGY IN THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA.

In injury of the femur I wish to propose a method for determining the presence of fracture, more particularly

intra-capsular or extra-capsular, with suggestions for its use elsewhere.

This method presents the advantage of determining the preternatural mobility in the direction of the axis of the bone. Allis's method, or rather the relaxation of the femoral fascia to which he has called attention, is suggestive of mobility upward of the trochanter, but does not in the least measure the degree of displacement, and may indicate only the fracture of the trochanter. In the method of measurement that I propose, the anterior superior spine of the ilium is taken as the fixed point on the pelvis and the inner condyle of the femur as the most suitable point on the extremity. Three measurements are made, which may be designated as: 1. Measurement of repose; 2. Measurement of tension; 3. Measurement of compression. The measurement of repose is made by taking the distance between the two points already given while the limb is lying quiet and in its characteristic position. The measurement of tension is then taken by making firm and somewhat prolonged extension in the axis of the limb; after which the measurement of compression or counter-extension is made, in which any shortening may be encouraged by slightly favoring the upward displacement of the lower fragment. This method of measuring is applicable to any and all fractures of the femur, and will afford corroborative evidence of fracture, except in the following cases: 1. Impacted fractures of either end of the femur. No information could be obtained by measurement in impacted fractures, at least by different measurements, and the objection advanced, that attempts at this form of measurement must break up impactions, cannot be considered as of more bearing than any other effort to diagnose a fracture of the femur; for example, attempts to obtain crepitus must be equally dangerous, as would also any attempt to ascertain the presence or absence of rotation of the fragment. 2. Fracture of the greater trochanter. Measurement, as suggested, would be quite useless, but if the measurement be made from the crest of the ilium to the trochanteric fragment there will be no alteration in the measurement, no matter how violent the attempt at extension or compression, provided the fracture is complete and the periosteum not retaining the two fragments in apposition.

I can but briefly outline this method of determining longitudinal mobility, and in the femur the lessened arc of rotation could be measured by taking a point on the pubic bone and measuring from that to the trochanter in complete eversion, followed by measuring in complete inversion, the difference marking the two arcs of rotation on the respective bones. If material difference between the two bones is discernible, there would be reason to infer that the two radii must be different. A similar measurement could be made from behind, taking a suitable point on the sacrum and measuring posteriorly to the right and left. This method may be found extremely useful in many forms of fractures elsewhere than in the femur, and will suggest itself whenever it can be used.

Quatrefages, a distinguished French physician and naturalist, died recently, in the eighty-second year of his age.

MEDICAL PROGRESS.

Aneurism of the Heart, with Symptoms of Angina Pectoris.—MACKENZIE and WILLIAMSON (*Medical Chronicle*, xv, 5, p. 302) report the case of a man aged fifty-eight, who, without the history of a frank attack of rheumatism, for three months presented symptoms of angina pectoris. On walking fast and during the paroxysms of pain there was increased secretion of saliva referred to the left side of the mouth. There was tenderness in the precordia and over the second dorsal vertebra. The sounds of the heart were faint, the first soft; but no murmur or other abnormality was detected. The patient suddenly expired while engaged in his ordinary pursuits. When the chest was opened, the pericardial sac was seen to be greatly distended. Incision disclosed the presence of a large quantity of clotted blood. On the posterior aspect of the left ventricle, about midway between the apex and the auriculo-ventricular groove, and about a quarter of an inch from the inter-ventricular groove, the wall of the heart was thinned in an oval area, at the lower part of which was a minute linear rupture. On the inner aspect of the ventricle, at a corresponding situation, was a pouch-like depression containing small, recent blood-clots. The floor of the aneurism was apparently constituted only of the endocardium and the visceral pericardium. The edges of the mitral leaflets were slightly thickened; the attached margins of the aortic valves were atheromatous. The sinuses of Valsalva, the coronary arteries, and the ascending aorta were also atheromatous. On microscopic examination the cardiac muscle appeared normal. It is believed that softening of a circumscribed area of the muscular structure of the heart resulted in consequence of the thrombotic obstruction of a branch of the coronary artery, with secondary aneurismal dilatation.

Pneumonotomy and Pneumonectomy.—In a paper read before the College of Physicians of Philadelphia, WILKARD (*University Medical Magazine*, iv, 5, 1892, p. 334) expressed the view that the entrance of air into the pleural cavity is a far more serious matter, as regards collapse of the lung and of the patient, when the pulmonary tissues are normal than when they are diseased. In dogs, incision and removal of portions of the lung were well borne; hemorrhage was free, but was arrested by packing. Adhesion of the parietal and visceral layers of the pleura was readily secured by means of sutures; the resulting pleurisy was slight. The practical conclusions to be drawn are that incision into tuberculous or gangrenous or suppurating pulmonary tissue can be safely undertaken. In case of gangrene and of abscess better results are to be expected than from other methods of treatment.

Tuberculosis of the Pericardium.—At a recent meeting of the Pathological Society of London, ROLLESTON (*Lancet*, No. 3558, p. 1042) presented the heart and pericardium of a child, nine months old, that had died with tuberculous meningitis. Lungs, spleen, mesenteric and bronchial glands contained caseous tubercles. The bronchial glands were adherent to the pericardium. The pericardial sac was enormously enlarged. Externally it was red and rough. When opened, about three ounces of

clear, yellowish fluid escaped. The parietal layer of the pericardium was everywhere greatly thickened and rigid. There were no adhesions between the visceral and parietal layers. Microscopically, the thickened tissues were found to consist of newly formed fibrous tissue containing bloodvessels, tubercles, giant-cells, and tubercle-bacilli.

Removal of the Uterus in Puerperal Peritonitis.—SMITH (*Amer. Journ. of Obstetrics*, 1892, xxv, 169) has recorded the case of a woman, thirty-five years old, delivered by a midwife. The placenta being retained, efforts at manual removal had been made. Symptoms arising that made doubtful a diagnosis between septicemia, appendicitis, and pyosalpingitis, abdominal section was performed, but nothing abnormal was found in connection with the peritoneum, oviducts, or vermiform appendix. It was decided, nevertheless, to remove the uterus. The operation was attended with no special complication, and the subsequent course of the case was uneventful. The removed organ was found to contain remnants of placental tissue in process of decomposition.

The Infectiousness of Carcinoma.—SCHOFF (*Wiener klin. Wochenschr.*, No. 45, 1891, p. 840) has recorded the case of a woman, fifty-two years old, in which, on account of carcinoma of the body of the uterus, vaginal extirpation was practised. The large size of the uterus necessitated the performance of episiotomy. At either cornu superficial gelatinous infiltration, and at the internal os a soft mass as large as a hazel-nut, were found. Three months after the operation neoplastic nodules were found in the lines of incision that had been made to facilitate the extraction of the uterus. The inference is that local infection took place as a result of contamination by cells or fluid, or both, in the course of the operation. The patient died somewhat later from a metastatic growth in the liver.

Double Optic Neuritis following Influenza.—LEE (*Liverpool Medico-Chirurgical Journal*, No. 22, p. 44) has reported the case of a blacksmith, sixty years old, in which three weeks after an attack of influenza failure of vision appeared, and progressed to blindness. There was nothing abnormal in the urine, and there were no evidences of disease of the nervous system. On ophthalmoscopic examination moderate optic neuritis was found on both sides, disproportionate to the degree of impairment of vision. Under treatment by means of mercuric chloride, potassium iodide, and strychnine, some improvement took place, though secondary atrophy resulted.

Chloroform as an Anesthetic.—As the result of an experience of forty years in the Rotunda Hospital, Dublin, with the anesthetic employment of chloroform, covering many thousands of cases, ATTHILL (*British Medical Journal*, No. 1620, p. 110) expresses the opinion that, with due care and attention, if the anesthetic be pure, if a proper inhaler be used, if the respiration and pulse be watched, and if a needful degree of anesthesia be steadily maintained, the use of chloroform is safe, certainly quite as safe as the use of ether, while its effects

are infinitely less disagreeable to the patient, both during and subsequently to inhalation.

The Union of Severed Fingers.—At a meeting of the Berlin Medical Society, GLUCK (*Deutsche medicin. Wochenschr.*, No. 46, 1891, p. 1273) presented a butcher who had accidentally severed the terminal phalanges of the ring and middle fingers of the left hand by means of a cleaver. As soon as seen, the resulting wound was disinfected and the parts were carefully sutured. Union took place and was perfect a year and a half later.

THERAPEUTIC NOTES.

Carbolic Acid in Influenza.—SIMSON (*British Medical Journal*, No. 1621, p. 171) reports the successful treatment of many hundreds of cases of influenza by means of carbolic acid. The following is a useful combination:

R.—Acid. carbolic, pur. liquid. . . . ℥ij.
Syrup. simplicis ℥xl.
Tinct. cardamom. comp. . . . ℥x.
Spts. chloroformi ℥x.
Aquaë menth. pip. . . . ad f 3j.—M.

S.—For an adult. To be taken every four or six hours.

The powder of opium and ipecacuanha, in ten-grain doses, was employed to induce sleep and promote perspiration. If cough was troublesome, a mixture containing about gr. $\frac{1}{2}$ of morphine, ℥v of dilute hydroboric acid, ℥ $\frac{1}{4}$ of pure chloroform, and sufficient of syrup of lemon and water to make a dram, was employed as required.

Suppositories for Chronic Prostatitis.—For chronic prostatitis, OBERLANDER recommends the employment of a suppository containing—

R.—Iodoformi gr. vij ss-xv.
Solve in
Ol. amygdal. dulcis q. s.
Adde
Ol. theobromæ q. s.
—ut ft. suppos. no. x.

S.—One to be introduced at night following an intestinal evacuation.

The oil of sweet almonds increases the absorbability of iodoform. The proportion of iodoform in each suppository is slowly increased from three-quarters of a grain to a grain and a half. In susceptible individuals larger quantities may occasion toxic symptoms.—*Deutsche med. Wochenschr.*, No. 53, 1891, p. 1435.

The Cure of Pulmonary Tuberculosis.—In an interesting address before the Medical Society of London, BURNLEY YEO (*British Medical Journal*, No. 1620, p. 106), after considering the conditions of cure in pulmonary tuberculosis and referring to the utility of climate, air, food, and exercise in treatment, added that he had observed some excellent results from the employment of rectal injections of sulphuretted hydrogen, as also some good results from the employment of tuberculin. Of the latter

he expressed the opinion that it would survive in a modified form. Antiseptic medication, faithfully employed for long periods, exerts a favorable influence upon the course of pulmonary tuberculosis. For internal administration the best agents are creasote and guaiacol.

The Treatment of Influenza.—In a lecture on influenza, BACCELLI stated that in cases marked by bronchial distress, concurrently with a feeble heart, camphor is decidedly useful in the first stage. Four grains of camphor in fifteen minims of olive oil may be injected beneath the skin every three or four hours. If camphor fail, injections of ether often succeed admirably. In other cases injections of strychnine, in doses ascending from a thirtieth of a grain every twelve hours, will often tide over a crisis. To sustain the vital powers hot wine may be given in small quantities at short intervals. In the gastro-enteric variety of influenza in the young and strong, ipecacuanha may be employed to induce emesis. When the respiration is embarrassed striking benefit is often derived from inhalations of oxygen.—*Lancet*, No. 3569, p. 220.

The Treatment of Carcinoma.—At a recent meeting of the Royal Society of Physicians of Vienna, ADAMKIEWICZ (*Wiener klin. Wochenschr.*, No. 47, 1891, p. 888) presented a case of epithelioma of the inner angle of the right eye, in which cicatrization had taken place in the course of treatment by means of subcutaneous injections of a substance called cancrin that, it was claimed, exerted a specific influence upon carcinoma.

BILLROTH, KAPOSI, DITTEL, and others, however, maintained that the progress of the case was not unusual and were unwilling to admit any specific action or curative result not to be obtained by other methods of treatment.

For Baldness.—One of the best combinations in the treatment of baldness consists of:

R.—Pilocarpinæ hydrochlorat. . . gr. v.
Otto de rosæ ℥viii.
Olei rosmarini f 3iv.
Liniment. cantharid. . . . f 3iv.
Glycerini pur. . . . f 3j.
Olei amydal. dulcis . . . f 3ij.
Spts. camphoræ f 3iij.—M.

S.—To be rubbed well into the scalp, night and morning. WHITLA.

The Relief of Vomiting.—KENNY (*British Medical Journal*, No. 1618, p. 16) has reported the case of a parturient woman, in whom he overcame obstinate vomiting, resistant to other means of treatment, by the application of a cantharidal blister over each pneumogastric nerve at the anterior border of the sterno-mastoid muscle.

Ammonium Bromide and Antipyrin in Epilepsy.—In a second series of cases reported, POTTS (*University Medical Magazine*, iv, 5, 1892, p. 345) confirms the favorable results previously obtained in the treatment of epilepsy by means of a combination of ammonium bromide (twenty grains) and antipyrin (eight grains).

THE MEDICAL NEWS.

A WEEKLY JOURNAL

OF MEDICAL SCIENCE.

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Subscription Price, Including Postage in North America.

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SATURDAY, MARCH 5, 1892.

EXPERT TESTIMONY.

DISCUSSION of the much-discussed questions connected with the status in judicial proceedings of the so-called "medical expert," and his testimony, has been reawakened by a recent trial in New York.

We do not wish to comment at this time upon the testimony offered in the Harris trial, for the reason that an official report is not in our possession; while one of the eminent physicians who testified for the defence, PROFESSOR H. C. WOOD, of this city, has publicly stated at a meeting of the College of Physicians, that "the nonsense telegraphed in his name all over the country" was not uttered by him. Nevertheless, the fact remains, that in a case in which the life of the prisoner was at stake, testimony in direct conflict was given for the prosecution on the one hand, and for the defence on the other hand, by medical experts of unblemished reputation and of the highest rank as scientific men and teachers. Under such circumstances, what course is an intelligent juror to pursue? When suspicion of venality attaches to an expert witness, a jury can honestly ignore his testimony; but the most degraded of medical men would hardly sell himself to the prosecution in a criminal case; and it might well be in every instance, as it undoubtedly was in

the recent trial at New York, that the personal and scientific character of the expert witnesses for the defence should be beyond suspicion. The experts upon either side, then, being equally trustworthy, and, so far as the jury can know, equally authoritative, what is to be done when the sworn evidence of the one is directly contradictory of that of the other? Shall the juror, with no special fitness of knowledge or training, attempt to decide the questions at issue? Evidently he can do this more readily without expert testimony than with it; for then, at least, he will not be setting his opinion against that of the specialist presumably better fitted to form an opinion. Shall he ignore the expert testimony altogether, and decide as to the guilt or innocence of the prisoner without reference to the questions involved in the evidence of the experts? Obviously such a course would be most unjust to the prisoner and unfair to society, for the cause of death, for example, must be an important link in the chain of evidence establishing the fact that murder has been committed, and fixing responsibility for the crime upon this or that individual. When the questions in dispute involve a matter of such gravity, one horn or the other of the dilemma must be chosen, if other decision is to be reached than the Scottish verdict—"Not proven." As American practice justly requires the acquittal of an accused person of whose guilt the jury entertains a reasonable doubt, the only right way out of the dilemma is acquittal. Thus justice must often miscarry, for how can a jury fail to have reasonable doubt when equally reliable and directly opposing evidence is offered on both sides?

None of these three methods—decision on technical subjects by an untrained jury, ignoring of the subject-matter of expert testimony, or acquittal because the jury has been befuddled—can be satisfactory. Is there any escape from the difficulty? It has been held—and the secular press has urged this view with some asperity—that the difficulty arises only because each side presents witnesses who are not impartial, but occupy the position of hired advocates: their duty being not to show all the facts in the case, but merely those most advantageous to the side they represent. From this point of view it is contended that the present method of securing expert testimony should be abandoned; that the expert should be an officer of the court, and that it should be his duty to investigate the facts of the case impartially, and present his con-

clusions as a judicial report, to be accepted by the jury without question. This easy solution of the problem, however, ignores the real crux. The medical sciences are not yet exact. It is only upon doubtful matters that conflicting testimony can be offered. In a case so plain that under the plan proposed the report of an official expert could be accepted by both sides unquestioned, it is extremely improbable that, even under present faulty procedure, the most astute lawyer could befog a jury without the aid of a venal witness. When the case is not so plain, the official expert must either report himself in doubt and let the jury decide, or the subject must be ignored, or the doubt must lead to acquittal—the same triad of unsatisfactory possibilities as before; or else the side against which he reports will bring its experts to criticise the report, and the other side will bring experts to uphold the report, and the same conflict of testimony confronts us once more.

On the whole, however, the method of investigation and report by an officer of the court, whose character and attainments and the manner of whose appointment are unexceptionable, has several advantages. His investigation would be deliberate; his report would be thorough and complete; bribery aside—and we are assuming bribery to be impossible—he would have no temptation to favor one side or the other; and in the course of such investigations as examination of organs and chemical analyses the whole process could be watched by a representative of the accused, whose criticisms could be made and met at the time. This plan differs from the practice that prevails in France and Germany, where we believe the accused is not represented at the investigation. The accused, moreover, should still have the right to dispute the correctness of the conclusions of the official expert, and in matters of opinion—for example, as to the significance of certain symptoms—conflicting testimony on both sides must be expected.

The animadversions of some writers in the secular press upon the testimony of medical experts is most unfair and unjust to an honorable body of men. Everyone is entitled to have his case exhibited in the best light possible; and all are agreed that it is better for a guilty man to escape for want of proof than for an innocent man to be unjustly convicted. There is absolutely no means of securing unanimity of opinion upon matters not subject to rigid demonstration; and in the present state of science it is only a minority of the questions

arising in medical jurisprudence that are thus subject. A brilliant instance of rigid scientific demonstration was, however, afforded by the testimony of PROFESSOR FLINT in the recent trial of a character known as "Frenchy," and this testimony undoubtedly secured the conviction of the prisoner.

The sages of the Talmud said that "Truth was the child of Disputation." On the whole, the ends of justice are substantially served by getting all the facts and all their opposing bearings upon the record; and as we have shown, the inherent difficulty that cannot be gotten over by any device is simply this, that "doubtful things are mighty unsartin."

AFFAIRS AT THE JEFFERSON MEDICAL COLLEGE.

THE graduates and friends of Jefferson College and of medical education will be glad to learn of the success of the trustees in securing for the college a new site, to which it is intended to remove so soon as the proper buildings can be erected. A large area has been secured on South Broad Street, and the committee are now considering questions of construction, plans of buildings, etc.

The splendid record of work done throughout the long period of her history—the great men who have been teachers and pupils within her walls, the living monument of her ten thousand graduates—has placed the name and tradition of Jefferson in every part of our own country, and, indeed, of the civilized world, and has developed an historic momentum that should be utilized and made to serve the highest interests of civilization. In consonance with this history and possibility of usefulness and power, it now behooves her officers and alumni to seize with firm grasp the proffered opportunity of renewed life.

The old methods of institutional usefulness and work have in great part, as we all know, been outgrown, and with new science and civilization has come the need of changed methods of teaching and of research, of enlarged laboratory facilities, the free subdivision of departments, etc. Science is democratic, our nation is democratic, and, in accordance with the demands of this progressive age and of the prevalent sociological spirit, teaching facilities and functions must be multiplied and enlarged, fresh talent welcomed and pressed into service.

It is simply absurd to suppose that any single

man can drill and outfit several hundred students in one of the seven chief branches of medical science. An immense augmentation of the teaching force is demanded to conform to the educational necessities and standards of to-day.

There can be no doubt of the advisability of the endowment of chairs in all medical schools, so that even that suspicion of influence may be avoided which must exist so long as Faculties have a financial reason for receiving the largest possible number of matriculants, and for sending forth the largest possible number of graduates. It is high time we had learned the evident truth, that in medical education quality must be rated far higher than quantity.

It is also very desirable that the new move shall enable Jefferson to lead in the great reform her history has marked out for her—a practical, clinical, bedside method of teaching. All the instruction exclusively didactic and the operations only looked at cannot render the student competent to do the future physician's and surgeon's work. The immense hospital *clientèle* should be utilized for the benefit of the student and his future usefulness. Here is the place for the hundred times multiplied corps of clinical instructors and drillmasters in the routine work of the diagnosis and treatment of common diseases. In the large clinics it is too commonly true that rare cases and curiosities and the "show operations" too exclusively occupy the attention, while the simple every-day diseases—the all-important things for the student—are neglected, and the veriest rudiments and elements of clinical experience are not gained.

To live and grow, the institution of the future must be officered by men of a high ideal and endowed with a large morality. The teaching of the future must be drudgery and work, for the benefit of the student and not of the teacher, with such systematic subdivision and military precision that a hundred harmonious departments shall conspire to produce men knowing how to find disease, knowing it when they see it, and instinct with therapeutic knowledge and power.

PUBLIC TEST-OFFICES.

AN important feature of the work to be done at the hygienic laboratory at the University of Michigan, at Ann Arbor, is the examination, at a nominal fee to cover actual expenses, of articles of food and

drink, on request of health-officers throughout the State. Such work is already done to a limited extent, but it is proposed hereafter to enlarge its usefulness by making it available to sanitary officers of the State.

The usefulness of such a laboratory could be still further extended by allowing citizens generally the privilege of having tested, at a nominal cost, not only suspected articles of food, but such articles of domestic use as are liable, at times, to contain poisonous substances. For a number of years there has been established in Paris a public test-office, where all articles of food, beverages, etc., are analyzed and tested by experts, who also perform the duties of inspectors of markets and among the tradesmen. For a nominal sum, and in some cases gratuitously, anyone can ascertain the composition of any suspected article of food. Articles of domestic use, clothing, colored toys, wall-papers, etc., are also examined, in order to detect any poisonous ingredients that may be present.

The establishment of a public test-office would excite popular interest and be the means of instructing the people in matters closely connected with their physical well-being. Indifference to causes acting injuriously upon health is rightly attributed to the want of proper knowledge. The chrome-yellow poisoning in this city some years ago would never have reached the proportions it did, had the people been in possession of the knowledge that leads to suspicion.

It is very necessary to have test-offices and inspectors to search for deleterious articles of food or of domestic use, but it is quite as important to secure the coöperation of the public and keep active their interest in measures employed to prevent the sale or use of such articles. The public should be made to assume a share of the responsibility of noting and reporting suspected articles, and in no better way can this be accomplished than by offering free facilities for investigation.

The moral effect of establishing a bureau of investigation would be repressive if not preventive of practices now foisted upon the masses because of their supineness and lack of information. By freely offering the services of experts, the coöperation of the public would be secured, and as a result greater progress would be made not only in detecting, but also in breaking up harmful practices that are none the less common because they so generally escape notice.

THE FIRST INSTITUTE OF HYGIENE IN THE UNITED STATES.

IN his address delivered at the opening of the Institute of Hygiene of the University of Pennsylvania, and published in THE MEDICAL NEWS of February 27th, DR. BILLINGS stated that "this is the first structure of its kind erected in the United States." In the year 1888 a building was erected for the use of the Hygienic Laboratory of the University of Michigan, at Ann Arbor. According to the official calendar of 1888-89, this building "contained a large room for general work in hygiene, a lecture-room, a microscopical room, separate rooms fitted especially for gas analysis, water analysis, and bacteriological work; a disinfecting chamber, a cold chamber, and three private rooms for original research. The laboratory is furnished with all necessary chemical, optical, and bacteriological apparatus. A full set of KOCH's bacteriological apparatus is in use. The chief purpose of this laboratory is to furnish proper facilities to those who are competent to carry on original investigations in hygiene, and it is open to any such person who desires to pursue special lines of investigation, provided he comply with the requirements for admission to the literary or the medical department of the University." Courses of instruction were given by DR. VAUGHAN and MR. (now DR.) NOVY upon Sanitary Science, Sanitary Examinations, Analytical Chemistry, Original Research on the Causation of Disease, including a Course in Bacteriology. In the friendly competition in the scientific world it is only just that credit and priority be given when due, and it is with the view of correcting any possible misapprehension that the foregoing facts are recorded.

PLAGIARISM EXTRAORDINARY.

THE MEDICAL NEWS presents its compliments to *The Western Medical Reporter*, and to a contributor to its issue of February, 1892—one CHARLES C. KOHNING, M.D., of Brussels, Ill. The editors of *The Reporter* are evidently not such good readers of THE NEWS as their contributor. The latter writes an article presumably original, but which is copied *verbatim* from the article of PROFESSOR GOODELL in THE MEDICAL NEWS of November 29, 1890. DR. GOODELL's paper was entitled, *What I Have Learned to Unlearn in Gynecology*. DR. KOHNING omits the word *have* in his title. There is one original sen-

tence in Dr. KOHNING's article, and that, as so often occurs, proves that the gentleman has also other educational and original qualities: "*As proof of this see American Indian and several other nations.*" A funny typographical blunder completes the evidences of originality. DR. GOODELL spoke of a medieval superstition—the belief in two seeds, the male and female semen, etc. To the medieval ignorance is added the modern, and we have "the existence of hoo-seeds"—with an apt exclamation point!

PROGRESS IN THE UNIVERSITY OF BUFFALO.

WE are glad to learn of the zeal and energy manifested among the officers and friends of the Medical Department of the University of Buffalo. A noble building is being erected, which will be one of the finest and best equipped in the country. At the opening of the next session the three departments of medicine, pharmacy, and dentistry will occupy this new home, and enter with fresh spirit upon what cannot fail to be a new and larger career of usefulness. The medical department has long been recognized as among our best medical schools, with an exceptionally able corps of teachers; and in upholding and leading the movement for a higher standard of medical education, the officers of this institution are to be congratulated and complimented for their success and for the work done, as also encouraged with best good-will toward the realization of further work promised.

SELECTIONS.

THE STATE BOARD OF HEALTH AND THE LABORATORY OF HYGIENE OF THE UNIVERSITY OF PENNSYLVANIA.

At a regular meeting of the State Board of Health and Vital Statistics of the Commonwealth of Pennsylvania, held November 12 and 13, 1891, a communication was received from the Trustees of this University announcing the early opening of its new Laboratory of Hygiene, and presenting a brief curriculum of the proposed line of instruction; whereupon the following resolutions were adopted:

"*Resolved*, That this Board has received with sincere satisfaction the formal announcement of the approaching opening of the Laboratory of Hygiene of the University of Pennsylvania, considering that this event marks an era in the progress, not of science only, but of civilization, in this State.

"*Resolved*, That the Secretary be instructed to communicate with Dr. William Pepper, Provost of the Uni-

versity, and with Dr. John S. Billings, Director of the Laboratory of Hygiene, suggesting a conference for the purpose of formulating a plan by which this Board may avail itself practically of the facilities to be afforded by the Laboratory for the investigation of disease, and of the means for its prevention, for the analysis of foods, water and other beverages, and for bacteriological studies.

"Resolved, That in a definite coöperation between the University and the State Board of Health in the prosecution of such researches this Board recognizes an opportunity not only for mutual aid, but for advantage of the greatest moment to the entire Commonwealth."

In accordance with the foregoing resolutions such a conference has been held, and to me has been assigned the duty of briefly stating the conclusions which were reached, premising, however, that they have not as yet been submitted to the Trustees, and may be, to some extent, modified before either body is called upon to consider them.

The necessity of a Laboratory of Hygiene to the State Board of Health has been urgently felt, and arises out of the duties imposed upon the latter by Section 5 of the Act of Assembly establishing it, which reads as follows:

"The State Board of Health and Vital Statistics shall have the general supervision of the health and lives of the citizens of the Commonwealth, and shall especially study its vital statistics. It shall make sanitary investigations and inquiries respecting the causes of disease, and especially epidemic diseases, including those of domestic animals, the sources of mortality, and the effects of localities, employment, conditions, habits, food, beverages, and medicines on the health of the people. It shall also disseminate information upon these and similar subjects among the people. It shall, when required by the Governor or the Legislature, and at such other times as it deems important, institute sanitary inspections of public institutions or places throughout the State."

Now, to carry out in any adequate degree the purposes of the law with regard to investigating the causes of disease, and the effects of foods, beverages and medicines on the health of the people, two things, among others, are absolutely essential: first, that the Board should have means and opportunities for making or procuring chemical analyses; and, second, that it should have means and opportunities for prosecuting what are now known as bacteriological examinations, the study of the germs of disease. And it goes without saying, that where the interests of the health and lives of five million people are concerned, these means and opportunities should be on a generous scale, and should conform to the most recent developments of scientific hygienic research, both in this country and in Europe. It does not at all meet the intention and requirements of the statute, that the Secretary of the Board should spend a few cents on test-tubes and chemicals or press his old Dolland microscope, handed down from a previous generation, into the service of the State. Nor is it fitting that this great Commonwealth, with its millions of revenue, should be depending, as it has done—I say it with burning cheeks—on the charity of private chemists, who have, in a spirit of generous patriotism, placed their services at the disposal of the Board in order to

enable it, in some slight degree, to meet the claims that are constantly and properly made upon it for the analysis of suspected waters and foods. It is hoped, therefore, that the Trustees will see their way clear to allowing the Board to refer applications of this kind to the Laboratory for investigation. The Board, for its part, will make every effort to obtain from the Legislature a reasonable appropriation for such purposes, distinct from its general appropriation, which will enable it to meet at least the cost of all work done for the State. Further, Section 9 of the Act creating the Board instructs it "from time to time to engage suitable persons to render sanitary service or to make or supervise practical and scientific investigations and examinations requiring expert skill, and to prepare plans and reports relative thereto." Observe the phrases, "suitable persons," "expert skill." Heretofore the Board has been compelled to call to its aid for these objects simply medical men—intelligent, educated, sound practitioners, but without that special training and equipment which would render them "suitable persons" in any strict, technical construction of the expression, or would furnish them with "expert skill." Here, again, the laboratory will prove the right hand of the Board, giving just that instruction which a sanitary inspector needs to fit him for his special work. And, on its side, it will be the object of the Board to pursue more persistently, even than it has in the past, its purpose of obtaining a thorough sanitary organization of the State under legislative sanction and compulsion, the result of which will be to create a constantly increasing demand for just such trained practical sanitarians as this school will graduate. In this view of the case it might be the part of wisdom for you, gentlemen, Trustees, to place a certain number of scholarships at the disposal of the Board.—*From the address of Benjamin Lee, A.M., M.D., Ph.D., Secretary of the State Board of Health of Pennsylvania, at the opening of the Laboratory, February 22, 1892.*

WASHED AIR FOR HOSPITALS AND ASSEMBLY ROOMS.

An ingenious method of purifying and clarifying air intended for ventilation is in practical and continuous operation in the wards of the Victoria Infirmary at Glasgow. The air is renewed six times an hour. Before it enters the wards it is filtered and washed by being passed through an air-washing screen of cords, formed of horsehair and hemp, closely wound over a top rail of wood and under the bottom rail, forming a close screen sixteen feet long by twelve feet high, affording nearly 200 square feet of surface. There is a constant trickling of water over this screen, by which it is kept wet, and the air, in filtering through it, has the dust and soot particles removed; when once these have adhered to the wetted surfaces a current of air of considerable velocity will not carry them through the screen, but the falling water floats them down into the drain. An automatic flushing-tank is fixed in a position whereby twenty gallons of water is instantaneously discharged over the surface of the screen every hour, to remove any accumulation of wetted dust, soot, or germs that may not be removed from the screen by the water trickling over its surface.

This goes on day and night, and in the district where

the infirmary is built—near to the Queen's Park, the atmosphere of which is supposed to be the purest in the city—a very considerable amount of soot particles is extracted by this screen. Indeed, it is stated that a piece of jute Hessian cloth that was placed in the air-current in front of the screen, in six hours became nearly as black as graphite. It is alleged that one of the chief advantages of the screen is the facility with which it removes every vestige of fog; and that during the past winter, when there were many days of fog of great density, within this building, as soon as this screen was passed, the air was beautifully clear and bright. After passing the wet screen the air is warmed by coming into contact with steam-heated coils.

The air enters each ward by wide, shallow ducts, placed along the wall five feet above the floor; the incoming air is directed toward the ceiling and is diffused; it drives out through openings at the floor levels the air that had previously filled the ward. Recent experiments made on the quality of the air taken from three feet above the floor and three feet below the ceiling are stated to have shown that the air at three feet from the ceiling had no organic matter in it, and that the air of the ward generally was almost entirely free from microbes or moulds.—*British Medical Journal*, No. 1622, p. 255.

CORRESPONDENCE.

PRACTICAL METHODS OF SANITARY INSPECTION.

To the Editor of THE MEDICAL NEWS,

SIR: Your recent editorial article on the inspection of dairy cattle calls attention to a very generally overlooked department of State and municipal sanitary work. The dangers of meat and milk from diseased cattle are so evident, that they should no longer give rise to argument, but the question as to what per cent. of our food-supply from this source is affected is one that demands the most earnest attention of all practical sanitarians. I am convinced that quantities of diseased meat and milk are often sold by those who are ignorant of its character and who really believe it to be of the best quality. As an illustration, I may mention that our meat-inspector has more than once found it necessary to condemn meat just received from Kansas City, bearing the stamp of approval of the government inspectors at that point. In some of this "approved" meat abscesses have been found at or near the vertebrae or deeply seated in the loin.

It is most difficult for municipal boards of health to exercise authority in these matters, for if any obstinate shipper chooses to dispute their authority, he can give them an endless amount of trouble. It is indeed fortunate that in very many instances the shippers are anxious to do what is right and to coöperate with local authorities in these inspections. But the interests of a community ought not to depend on the whims or good humor of any interested parties, however honest their intentions, because it is hard to say at what time interest may blind their eyes. State boards of health should exercise jurisdiction over such matters, so that small communities would not be forced to go to the expense

of maintaining a system of food-inspection in order to protect themselves against the importation of diseased meats.

The field for the local board of health seems to be broad enough if only home-killed meat and the regular milk-supply of the city are properly inspected. By a wise exercise of the power of issuing licenses to milk-dealers, the city or town may find a way of stretching its authority over the dairies beyond its limits, the milk of which forms part of the city's supply.

In this city we have found such a plan to work well, and the dairyman who will not submit to an inspection of his dairy, barns, cows, and pasture, understands that he runs the risk of having his license revoked, in addition to the added ruination of publication in the daily papers of his refusal, with the reasons therefor.

I enclose copies of the blank forms¹ used for making a record of these dairy-inspections, which are conducted by the meat and milk inspectors together. In addition,

| | | | |
|--|--|---|---------------------|
| 1 No. | Date | Name | No. in family |
| Residence | | | |
| Habits | | Previous sickness | |
| Disease | | time of history | |
| Number affected | | frame, brick | |
| House: age | | No. of floors | No. of rooms living |
| | | sleeping bath, closet, kitchen sink, connected with | |
| Rooms | | ventilated; dry, damp. | |
| Plumbing | | | |
| Cellar: size | | walls | floor |
| damp, dry | | ventilated. | |
| Ventilation under house | | | |
| Previous sickness in house | | | |
| Premises: No. of lots | | proportion covered | |
| Sewer connection | | | |
| Cesspool; leaking, tight; privy-vault; leaking, tight; hopper, plunger | | Water-supply | |
| Milk-supply | | | |
| Disposal of slop | | of garbage | |
| Adjacent premises; condition | | | |
| Alley | Ditch | Shade trees | |
| Daily inspection No. | Name of Dairy | Location | |
| Owner | No. of Certificate | When issued | |
| Sickness in house: What | When | How long | |
| Previous Inspections of Dairy, when | No. | Result | |
| Previous Inspections of Milk, when | No. | Result | |
| No. of Wagons | Sections of City supplied | | |
| No. of Cows | Kind of pasture | Area | Feed in Winter |
| Stable: Size | Height of Roof | Material | No. of stalls |
| | Distance from house | Direction, up, down hill | |
| | Distance from well | Direction, up, down hill | |
| | Material of floor | clean, unclean. | |
| | Drainage good, bad, indifferent; into what | | |
| | Disposition of Manure: Temporary | final | |
| | Distance of manure pile from house | from well | |
| | Source of Water-supply: For persons | for cows | |
| | Distance to house to stable to privy to cesspool | | |
| | to manure pile | | |
| Milking: When done | by whom | | |
| Milkers: Male | female | clean, unclean. | |
| Examination of Cows: Clean | Ever curried | | |
| How many healthy | How many unhealthy | | |
| Cows condemned | Sickness or disease | | |
| Milk: Where milking is done | Milk stored until delivery | | |
| How long | Kind of vessels | Amount | |
| Specific gravity | rich, poor, per cent. of cream | | |
| Per cent. of solids | Per cent. of water | | |
| Adulteration | No. of samples taken | | |

we have added to our list of routine questions asked in the sanitary inspection of houses in which any contagious disease has existed, this one of "milk-supply."

During last week the inspectors found it necessary to kill two dairy cows, one for pleuro-pneumonia and the other on account of tuberculosis. In each instance the lungs and omentum were removed and brought to the Health-office, where the diagnosis was confirmed.

In conclusion, every city ought to have a system of inspection of the dairies from which the citizens obtain their milk-supply; the dangers of infected milk are too hideous to be overlooked by any properly conducted Health-office. A little money expended in this work will do an amount of good work that can never be measured by dollars and cents. And if a whole year's work were to give no greater results than those obtained by our inspectors in the one week mentioned, it would still be well worth the money outlay.

Very respectfully,

WM. P. MUNN.

DENVER, COLORADO.

SCARLATINA OR RÖTHELN.

To the Editor of THE MEDICAL NEWS,

SIR: IN THE MEDICAL NEWS of February 13, p. 186, Dr. W. R. Lee reports a number of cases that, by reasoning and exclusion, he considers as scarlatina. I have had a similar experience; the sequelæ were like those in Dr. Lee's cases, except that in four there was evident desquamation. I was in a quandary as to a diagnosis, for the cases were among young and old, and I could trace the spread by contact—visiting neighbors, etc.

In the course of my investigations I found the article of Malcolm Morris on "Rötheln, or German Measles," with the description of which my cases best accorded. There is, however, a good deal of risk attendant upon a diagnosis of Rötheln, with the permission for the patient to come in contact with other persons. It is safer to consider a doubtful case as one of scarlatina, and to isolate it and treat it accordingly.

In one case, in a child, the onset was sudden, with vomiting; the rash was distinct; the strawberry tongue was plain; the glands were swollen, also the uvula, tonsils and posterior walls of the pharynx; the pulse was 140; the temperature 103.6°. On the following morning, however, the pulse was 90, the temperature 99°; the rash was distributed all over the body, except on the neck and face. The redness disappeared on pressure, but at once returned when the pressure was removed. In only one or two of all the cases did the rash appear upon the face.

Morris describes Rötheln as an acute infectious disease, characterized by an eruption of red blotches, slight sore-throat, coryza, and but little constitutional disturbance. If the spots be large, they are generally irregular in shape; if they be small, they are more crowded together and present an appearance more resembling the eruption of scarlatina. He speaks of the rash as appearing on the face, but in my recent cases there was none on the face; although in some similar cases seen four years ago the rash did appear on the face. The rash lasts about two days and then fades away, leaving a slight brown stain that gradually disap-

pears; it is rarely followed by desquamation, and if at all, in minute scales. In my cases, except in those sick before the rash appeared, the rash faded within from forty-eight to seventy-two hours, and the desquamation was scaly. The constitutional symptoms that accompany the appearance of the rash are chiefly those of catarrh, and occur at the same time as the rash appears or precede the rash by less than twelve hours—not by some days, as in measles.

The tongue is coated with white fur, through which a few large papillæ can be seen (our strawberry tongue), more often at the tip than elsewhere (such was the case in my patients). The fauces are somewhat injected and the tonsils may be swollen.

An important symptom is the tendency of the lymphatic glands to become enlarged. This is more constantly the case with the glands of the neck, especially with those situated behind the sterno-mastoid muscles, but the glands of other parts of the body are not always exempt, as two of my patients complained of swellings in the groin, where the lymphatic glands were swollen and tender. The prognosis is favorable. No special treatment is required.

As in many families in this vicinity one or other member has presented the rash without the attendance of a physician, and as I was consulted in only two or three cases, I am inclined to adopt the diagnosis of German measles, or Rötheln.

A. D. AYER, M.D.

CHARLOTTESVILLE, INDIANA.

NEWS ITEMS.

United States Marine-Hospital Service.—A Board of Officers will be convened in Washington, May 2, 1892, for the purpose of examining applicants for admission to the grade of assistant surgeon in the United States Marine-Hospital Service.

Candidates must be between twenty-one and thirty years of age, graduates of a respectable medical college, and must furnish testimonials from responsible persons as to character.

The following is the usual order of the examination: 1. Physical. 2. Written. 3. Oral. 4. Clinical.

In addition to the physical examination, candidates are required to certify that they believe themselves free from any ailment which would disqualify for service in any climate.

The examinations are chiefly in writing and begin with a short autobiography by the candidate. The remainder of the written exercises consists in examination on the various branches of medicine, surgery, and hygiene.

The oral examination includes subjects of preliminary education, history, literature, and the natural sciences.

The clinical examination is conducted at a hospital, and when practicable candidates are required to perform surgical operations on the cadaver.

Successful candidates will be numbered according to their attainments on examination and will be commissioned in the same order, as vacancies occur.

Upon appointment, the young officers are, as a rule, first assigned to duty at one of the large marine hos-

pitals, as at Boston, New York, New Orleans, Chicago, or San Francisco.

After four years of service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon.

Promotion to the grade of surgeon is made according to seniority and after due examination, as vacancies occur in that grade. Assistant surgeons receive sixteen hundred dollars, passed assistant surgeons eighteen hundred dollars, and surgeons twenty-five hundred dollars a year. When quarters are not provided, commutation at the rate of thirty, forty, or fifty dollars a month, according to grade, is allowed.

All grades above that of assistant surgeon receive longevity pay, 10 per centum in addition to the regular salary for every five years' service up to 40 per centum after twenty years' service.

The tenure of office is permanent. Officers travelling under orders are allowed actual expenses. Further information or invitation to appear before the Board of Examiners may be obtained by applying to the Supervising Surgeon-General, Marine Hospital-Service, DR. WALTER WYMAN.

Association of American Physicians.—The annual meeting of the Association of American Physicians will be held May 24, 25, and 26, 1892, in the Medical Museum and Library, Washington, D. C.

The subject selected for discussion is "Dysentery." Dr. William T. Councilman, as referee, will consider the etiology and pathology, and Dr. A. Brayton Ball, as co-referee, the symptomatology, complications, and treatment.

The following members will present papers:

Henry M. Lyman: The President's Address. Charles Carey: The Production of Tubular Breathing in Consolidation and Other Conditions of the Lungs. Samuel C. Chew: (Title to be announced). William C. Dabney: A Contribution to the Study of Hepatic Abscess. I. N. Danforth: Tube Casts and their Diagnostic Value. George M. Garland: The Treatment of Follicular Tonsillitis. Heneage Gibbes: The Morbid Anatomy of Leprosy. Hobart A. Hare: A Collective Investigation in Regard to the Value of Quinine in Malarial Hematuria or Malarial Hemoglobinuria. A. Jacobi: (Title to be announced). W. W. Johnston: Treatment of Acute Dysentery by Antiseptic Colon and Rectal Irrigation. Thomas S. Latimer: Alcoholism. Morris J. Lewis: A Study of the Seasonal Relations of Chorea and Rheumatism for a Period of Fifteen Years. Morris Longstreth: (Title to be announced). Francis T. Miles: A Case presenting the Symptoms of Landry's Paralysis, with Recovery. William Pepper: Report of a Case of Glanders, with Results of Bacteriological Study. T. Mitchell Prudden: (Title to be announced). George M. Sternberg: Practical Results of Bacteriological Researches. Charles G. Stockton: Misconceptions and Misnomers Revealed by Modern Gastric Research. William H. Thomson: The Significance of Intermission in Functional Nervous Diseases. Victor C. Vaughan: Certain Toxicogenic Germs found in Drinking-water. B. F. Westbrook: Studies in Hypnotism. James C. Wilson: Pulsating Pleural Effusions. George Wilkins: The Cold-water Treatment of Typhoid Fever.

The American Medical Association will hold its forty-third annual session at Detroit, Mich., June 7, 8, 9, and 10, 1892. Dr. J. S. Cain, of Nashville, Tenn., will deliver the Address in General Medicine; Dr. John B. Hamilton, of Chicago, Ill., the Address in General Surgery; Dr. Charles A. Lindsley, of New Haven, Conn., the Address in State Medicine. DR. HENRY A. WALKER, of East Detroit, is the Chairman of the Committee of Arrangements.

The International Medical Magazine is the name of a new monthly, edited by Dr. Judson Daland, and published by the J. B. Lippincott Company. The first number bears date of February, 1892. It consists of one hundred and twelve pages of reading-matter, made up of sixty-nine different articles, distributed among seventeen various departments.

Neurologist to Randall's Island Hospital.—At a recent meeting of the New York Board of Commissioners of Public Charities and Correction, Dr. William James Morton was appointed neurologist to the Randall's Island Hospital.

BOOKS AND PAMPHLETS RECEIVED.

Stirpiculture; or, The Ascent of Man. By A. P. Reid, M.D. Pamphlet, 1891.

The Microscope and Histology. By Simon Henry Gage, Associate Professor of Physiology. Third Edition, entirely rewritten. Part I: The Microscope and Microscopic Methods. Ithaca, N. Y., 1892.

Nursing in Abdominal Surgery and Diseases of Women. By Anna M. Fullerton, M.D. Illustrated. Philadelphia: P. Blakiston, Son & Co., 1891.

Leucocytes in Inflammation, etc. By William Travis Howard, Jr., M.D. Reprint, 1892.

A Case of Congenital Malformation of the Heart. By William Travis Howard, Jr., M.D. Reprint, 1892.

Diseases of the Skin. By W. Allan Jamieson, M.D., F.R.C.P. Edin. Third Edition, revised and enlarged. Illustrated. Philadelphia: Lea Bros. & Co., 1892.

Treatise on Diseases of the Lungs and Pleura. By the late Wilson Fox, M.D., F.R.S. Edited by Sidney Coupland, M.D., F.R.C.P. Philadelphia: P. Blakiston, Son & Co., 1892.

Pneumonic Fever. By Edward F. Wells, M.D. Reprint, 1892.

The Relation of Land Monopoly to Population Health. By George Homan, M.D. Reprint, 1891.

Land Liberation. By George Homan, M.D. Reprint, 1892.

Annual Report of the Supervising Surgeon-General of the Marine-Hospital Service of the United States for the Fiscal Year 1891. Washington: Government Printing Office, 1891.

Insomnia and Hypnotics. By E. P. Hurd, M.D. Detroit, Mich.: George S. Davis, 1891.

A Possible Source of Disease. By Charles Hope Merz, A.M. M.D. Reprint, 1892.

Relations Between Chorea and Epilepsy. By G. R. Trowbridge, A.M., M.D. Reprint, 1892.

COMMUNICATIONS are invited from all parts of the world. Original articles contributed exclusively to THE MEDICAL NEWS will upon publication be liberally paid for, or 250 reprints will be furnished instead of payment, provided that the request for reprints be noted by the author at the top of the manuscript. When necessary to elucidate the text, illustrations will be provided without cost to the author.

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